Implementation of Acute Care Services and Long-Term Services and Supports System Redesign for Individuals with an Intellectual or Developmental Disability

As Required by

Texas Government Code,

Section 534.054

Health and Human Services

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Executive Summary

The annual report on the Implementation of Acute Care Services and Long-Term Services and Supports (LTSS) System Redesign for Individuals with an Intellectual or Developmental Disability (IDD) is submitted in compliance with Texas Government Code Section 534.054.

Chapter 534 directs the Health and Human Services Commission (HHSC) to design and implement an acute care and LTSS system for individuals with IDD to improve outcomes; improve access to quality, person-centered, efficient, and cost-effective services; and implement a capitated, managed care delivery system and the federal Community First Choice Option (CFC). Chapter 534 also created the IDD System Redesign Advisory Committee (IDD SRAC) to advise HHSC in the development and implementation of the system redesign.

HHSC has made substantial progress on the IDD system redesign. Milestones achieved include:

- For acute care services only, between 2014-2016, completed the transition of all eligible recipients[1] of Medicaid IDD waiver programs and community-based intermediate care facilities for individuals with intellectual disabilities (ICF/IID) from Medicaid fee-for-service (FFS) to the following capitated managed care programs: STAR+PLUS and STAR Kids.
- Implemented the CFC option in 2015 to increase access to services for individuals with IDD, particularly those currently on interest lists for IDD waiver programs.
- Completed and published evaluations in early 2019 to inform managed care transitions and new legislation.
- Secured continued Money Follows the Person Demonstration (MFPD) funding to increase and enhance community supports to promote independence and prevent institutionalization of individuals with IDD.

House Bill (HB) 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and requires HHSC to establish a pilot program in STAR+PLUS prior to the transition of LTSS to managed care for individuals with IDD. HB 4533 also establishes a STAR+PLUS Pilot Program Workgroup (SPPPW) to advise HHSC in developing and operating the pilot program. STAR+PLUS Pilot Program milestones to date include:

- Development of a workplan and workgroups comprised of cross-agency state staff to inform pilot program development.
- Establishment of the SPPPW in February 2020.

[1] Individuals who are dually eligible with both Medicare and Medicaid were excluded from the acute care transition.

- Collaboration with IDD SRAC and SPPPW to inform the pilot program design including but not limited to eligibility criteria, services, and providers.
- HHSC is finalizing the dental study required by HB 4533 to inform dental benefits for pilot program participants.

Due to the coronavirus disease 2019 (COVID-19), pilot program planning activities were paused between March and May 2020. All HHSC advisory committee meetings were cancelled March 16, 2020 through May 15, 2020, adhering to federal guidance for social distancing. Additionally, internal pilot program workgroups were paused as HHSC staff focused on the response to the impact of COVID-19 on services and supports for Texans. Pilot program planning meetings resumed virtually in late May 2020.

In the coming year, to the extent possible considering any further impacts of the COVID-19 pandemic, HHSC will continue pilot program development in collaboration with the IDD SRAC and SPPPW; and continue to monitor the acute care transition to managed care and utilization of CFC services in collaboration with the IDD SRAC.

1. Introduction

Texas Government Code, Section 534.054 requires HHSC, in coordination with the IDD SRAC, to report annually to the Legislature on the implementation of the IDD system redesign. The report must include:

- An assessment of the system redesign implementation, including information regarding the provision of acute care services and LTSS to individuals with IDD under Medicaid and the effects of the redesign on its goals as set forth in Section 534.051, Government Code; and
- Recommendations regarding implementation of, and improvements to, the system redesign, including recommendations regarding appropriate statutory changes to facilitate implementation.

Further, Section 534.112 is added by H.B. 4533 and requires HHSC, in collaboration with the IDD SRAC and SPPPW, to report by September 1, 2026, an analysis and evaluation of the pilot program and recommendations for improving the program. The pilot program will implement by September 1, 2023 and operate for at least two years. The pilot program evaluation report will be included as part of the annual report required by Section 534.054 and must include:

- An assessment of the effect of the pilot on elements of the system such as access and quality, person-centeredness, integration, employment, appeals, self-direction, and attendant workforce;
- Benefits of providing STAR+PLUS Medicaid managed care services to persons based on functional needs as required in the STAR+PLUS Pilot Program including feedback based on the personal experiences of pilot participants (e.g., individuals and families served and providers);
- Recommendations about a system of programs and services for consideration by the Legislature, including recommendations for needed statutory changes and whether to transition the pilot to a statewide program under STAR+PLUS;
- An analysis of the experience and outcome of the following systems changes:
  - Comprehensive assessment instrument under Section 533A.0335, Texas Government Code,
  - 21st Century Cures Act2,
  - Implementation of Home and Community-Based Services (HCBS) settings rules3,
  - Provision of basic attendant and habilitation services required under Section 534.152, Texas Government Code (CFC).

[2] https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf
[3] https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

2. Background

Texas Government Code, Section 534.051 directs HHSC to design and implement an acute care and LTSS system for individuals with IDD to support the following goals:

- Provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs;
- Improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services;
- Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;
- Promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;
- Promote individualized budgeting based on an assessment of individuals' needs and person-centered planning;
- Promote integrated service coordination of acute care services and LTSS;
- Improve acute care and LTSS outcomes, including reducing unnecessary institutionalization and potentially preventable events;
- Promote high-quality care;
- Provide fair hearing and appeals processes in accordance with applicable federal law;
- Ensure the availability of a local safety net provider and local safety net services;
- Promote independent service coordination and independent ombudsmen services; and
- Ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.[4]

The 86th Texas Legislature amended Texas Government Code, Chapter 534[5], through HB 4533 and directed HHSC to establish a pilot program prior to the transition of LTSS to managed care for individuals with IDD. The pilot program will operate through the STAR+PLUS Medicaid managed care program and test the delivery of LTSS for people with IDD or people with similar functional needs through managed care. HB 4533 establishes a pilot program workgroup to work in collaboration with HHSC and the IDD SRAC.

HB 4533 requires a dental study to evaluate dental benefits provided through certain Medicaid waiver programs and Medicaid managed care to determine which

[4] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm#534.051
[5] Texas Government Code, Chapter 534, SUBCHAPTER C: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm

set of benefits is most cost-effective in reducing emergency department (ED) visits and inpatient hospital admissions due to poor oral health. The findings will inform recommendations regarding which dental services benefits should be provided to participants in the STAR+PLUS Pilot Program.

Additionally, HB 4533 updates the timeline for the phased transition of IDD LTSS and requires a plan for the transition of all or a portion of services provided through IDD waivers and ICF/IID services to managed care.[6] HB 4533 directs HHSC to transition all or a portion of the:

- Texas Home Living (TxHmL) waiver program to managed care by September 1, 2027;
- Community Living Assistance and Support Services (CLASS) waiver program by September 1, 2029; and
- nonresidential services in the Home and Community-based Services (HCS) waiver program and the Deaf-Blind with Multiple Disabilities (DBMD) waiver program by September 1, 2031.

HHSC must conduct a second pilot to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and ICF/IID services to managed care.[7]

[6] Texas Government Code, Chapter 534, SUBCHAPTER E: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm

[7] https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/resources/ltss-waivers.pdf

3. Implementation Activities

STAR+PLUS Transition

STAR+PLUS is a Texas Medicaid managed care program specifically designed to meet the health care and support services needs of adults who are 65 and older or have a disability. STAR+PLUS members receive a full package of health care benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program) and service coordination. In September 2014, many adults with IDD transitioned from Medicaid FFS to the STAR+PLUS managed care program for their acute care services.

In fiscal year 2019, an average of 562,538 individuals were enrolled in STAR+PLUS each month. Of that total, approximately 16,909 individuals were also enrolled in an IDD waiver or ICF/IID each month.

Eligibility

Adults with IDD receiving IDD waiver or ICF/IID services are eligible for STAR+PLUS for their regular (also called "acute care") health care benefits if they:

- Participated in the CLASS, HCS, TxHmL, or DBMD waiver programs; or
- Were in a community-based ICF/IID and not a state supported living center (SSLC); and
- Did not receive Medicare Part B, in addition to Medicaid benefits. Individuals who receive Medicare Part B as well as Medicaid are dually eligible and receive their acute care services through Medicare.

Services

Adults with IDD receiving IDD waiver or ICF/IID services who are in STAR+PLUS receive acute care services through one of five Medicaid managed care organizations (MCOs) contracted to operate the program. These adults continue to receive LTSS services through FFS.

STAR Kids Transition

STAR Kids is the Texas Medicaid managed care program for children and adults ages 20 and younger who have disabilities. STAR Kids members receive a full package of health care benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). In alignment with the requirements in Texas Government Code, Section 534.051, STAR Kids provides person-centered service coordination for children with disabilities and their families to support their needs related to health and independent living.[8]

In fiscal year 2019, an average of 159,585 eligible children and young adults were enrolled in STAR Kids each month. Of that total, an average of 4,962 eligible

[8] https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids

children and young adults were enrolled in an IDD waiver or community-based ICF/IID each month.

Eligibility

Children and young adults under the age of 21 with disabilities are eligible for STAR Kids if they:

- Receive Supplemental Security Income (SSI);
- Receive SSI and Medicare;
- Receive services through the Medically Dependent Children Program (MDCP) waiver;
- Live in an ICF/IID or nursing facility;
- Receive services through a Medicaid Buy-In program;
- Receive services through the Youth Empowerment Services waiver; or
- Receive services through the following waiver programs:
  - CLASS;
  - HCS;
  - TxHmL; or
  - DBMD.

Services

Children and young adults in STAR Kids receive acute care services and some Medicaid state plan LTSS and comprehensive care program services, such as private duty nursing and personal care services, through one of nine Medicaid MCOs contracted to operate the program. Children and young adults receiving IDD waiver or ICF/IID services continue to receive LTSS services, including CFC, through FFS.

STAR Kids Report

The state's external quality review organization (EQRO) conducted a multi-year study from 2016 to 2019 to evaluate the implementation of STAR Kids and develop a set of quality measures for the STAR Kids population. During the study, the EQRO evaluated and monitored utilization, quality of care, and satisfaction with care in STAR Kids, including an assessment of the relative performance of STAR Kids MCOs. The STAR Kids Focus Study Summary report (November 2019) is the final report in the multi-year study.[9]

Caregiver survey results found an overall improvement in access to specialized services[10]. However, members in the MDCP and IDD waivers experienced a small decrease in specialized services post-implementation which was not statistically significant after controlling for demographics and health status.

Access to care coordination improved significantly after implementation, particularly for members in MDCP and members not in an IDD waiver. However, only slightly more than one-third of all STAR Kids caregivers reported having someone to help

[9] More information can be found in the External Quality Review Organization Summary of Activities Report Contract Year 2018

[10] The study defines specialized services as physical, occupational, and speech therapies.

coordinate their child's care. The percentage of caregivers who said they could have used extra help with care coordination remained stable for members in MDCP and increased for members in IDD waivers. This suggests that, while availability of care coordination increased, the amount or quality of care coordination may not have been sufficient to meet the needs of some members.

STAR Health

STAR Health is the Medicaid managed care program for children and young adults in Department of Family and Protective Services (DFPS) conservatorship and children and young adults who are transitioning out of conservatorship.[11]

STAR Health is a statewide program that began April 1, 2008. STAR Health members receive a full package of health care and dental benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). STAR Health provides the same LTSS as STAR Kids. Superior Health Plan is the single MCO serving all children in STAR Health.

During fiscal year 2019, an average of 34,846 children and young adults were enrolled in STAR Health each month. Of that total, approximately 138 were enrolled in an IDD waiver or community-based ICF/IID each month.

Community First Choice

In June 2015, the CFC option became available for Texans, expanding basic attendant and habilitation services to individuals with disabilities meeting the criteria for an institutional level of care. Federal law allows the CFC option under Section 1915(k) of the Social Security Act. CFC services are provided in home and community-based settings. Services are not time- or age-limited and continue as long as eligible individuals need services and reside in their own homes or family home settings.

Eligibility

Individuals may be eligible for CFC services if they:

- Are eligible for Medicaid;
- Meet an institutional level of care;[12] and
- Have functional needs that can be addressed by CFC services.

Services

CFC services are provided by LTSS providers, including home and community support services agencies and service provider agencies for the IDD waiver programs. CFC services include:

- Personal assistance services
- Habilitation services

[11] https://www.dfps.state.tx.us/Child_Protection/Medical_Services/

[12] Meeting an institutional level of care means needing the level of care provided in a nursing facility, ICF/IID, or Institution for Mental Disease.

- Emergency response services
- Support management

Assessment

Since the initial implementation of CFC, HHSC collaborated with stakeholders to develop a revised uniform CFC assessment tool to serve multiple waivers and programs and achieve a streamlined and consistent assessment process. HHSC drafted a CFC Personal Assistance Services/Habilitation assessment form, which identifies a person's need for personal assistance and habilitation services, the amount of services, and service delivery preferences. HHSC obtained stakeholder feedback to improve the tool and researched how other states have implemented CFC to better inform the draft tool. At this time, without additional funding HHSC will not be able to validate the draft CFC assessment tool.

CFC for Non-Waiver Recipients

CFC provides an opportunity for people with IDD not currently receiving services in an IDD waiver to receive personal assistance and habilitation services. Eligible Medicaid beneficiaries no longer wait to receive these services through the waiver programs, which have interest lists. In fiscal year 2019, a total of 100,814 individuals were concurrently enrolled in Medicaid and on HCS, TxHmL, CLASS, and DBMD interest lists.[13]

Individuals may be on multiple interest lists at any given time, meaning that there is duplication across interest lists, and eligibility for waiver services is not assessed at the time people are added to the interest list. There are also people on the interest lists who are not already determined to be Medicaid eligible.

MCOs began using new procedure code combinations for STAR+PLUS Personal Assistance Services and CFC services on September 1, 2019. Due to this change, HHSC anticipates improved CFC reporting accuracy in the future and an increase in CFC utilization in managed care.

In fiscal year 2019, there were an average of 2,736 non-waiver recipients receiving CFC services each month through STAR, STAR Kids, STAR Health, STAR+PLUS and Dual Demonstration[14]. These individuals meet at least one of the eligibility criteria for institutional services: nursing facility, ICF/IID, or Institution for Mental Disease. Table 1 below shows the average monthly enrollment for non-waiver recipients by age group, and unduplicated CFC services provided in state fiscal year 2019.

[13] Unduplicated total of individuals on HCS, TxHmL, CLASS and DBMD interest lists in fiscal year 2019 with concurrent Medicaid eligibility in TIERS.

[14] The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and the Centers for Medicare & Medicaid Services (CMS) for the provision of the full array of Medicaid and Medicare services.

Table 1. Average Monthly Enrollment for Non-Waiver Recipients by Age Group, and Unduplicated CFC Services Provided in Fiscal Year 2019[15]

Program	Age Group[16]	Average Monthly Unduplicated Program Enrollment[17]	Average Monthly Unduplicated Individuals Utilizing CFC Services[18]
STAR[19]	0-20	N/A	118
STAR Kids	0-20	147,902	980
STAR Health	0-20	34,835	99
STAR+PLUS	21+	399,632	1,478
Dual Demonstration	21+	31,024	60
All Programs Combined	**0-20**	**182,868**	**1,197**
	21+	**430,667**	**1,539**
	All Ages Combined	**613,535**	**2,736**

CFC for Waiver Recipients

HCBS 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, ICF/IID, or hospital). STAR+PLUS HCBS program allows Texas to operate and expand Medicaid managed care by providing health care and LTSS, including home and community-based services, as an alternative to residing in a nursing facility. Individuals with IDD in Texas receive waiver services through both

[15] The current codes used for submitting managed care CFC service encounters may not be reported consistently to HHSC. As a result, the CFC data presented may not show the full CFC service utilization. Beginning September 1, 2019, new codes are being used by MCOs that HHSC anticipates will improve CFC reporting accuracy.
[16] An individual was counted as under 21 through the end of the month of their 21st birthday.
[17] The average enrollment members do not include members concurrently enrolled in a waiver, ICF/IID, or nursing facility. The STAR Kids, STAR Health, STAR+PLUS, and Dual Demonstration average enrollment numbers do not match the members in the body of the text on pages 8-11 because earlier enrollment numbers represent the entire managed care program, and the numbers in table 1 reflect non-waiver members who utilized CFC services.
[18] CFC utilization counts for all managed care programs (excluding STAR) based on encounter records from the TMHP Vision 21 Enc. Best Picture universe. All counts are unduplicated by client Medicaid number.
[19] CFC utilization counts for STAR based on acute care fee-for-service claims (CFC is carved out of managed care for children in STAR). All counts are unduplicated by client Medicaid number.

1915(c) waivers and the STAR+PLUS HCBS program[20]. CFC for waiver recipients is presented below based on the type of institutional level of care.

Intermediate Care Facility – Level of Care

HCS, TxHmL, CLASS, and DBMD waivers provide home and community-based services as an alternative to residing in an intermediate care facility. As outlined in Table 2, an average of 39,001 individuals with IDD were enrolled in the four IDD waiver programs each month during fiscal year 2019, with nearly three-quarters of the individuals served enrolled in HCS.

CFC services were utilized at the highest rate by all ages in CLASS, with an average of approximately 5,204 individuals in CLASS receiving CFC services each month out of the total 12,110 individuals each month across all four waiver programs.

Table 2. Average Monthly Enrollment in IDD Waivers by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2019

Waiver Program	Age Group[21]	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers[22]	Average Monthly Unduplicated Individuals Utilizing CFC Services [23]
CLASS	0-20	1,679	**1,484**
	21+	3,845	**3,720**
	All Ages Combined	5,524	**5,204**
DBMD	0-20	158	**107**
	21+	196	**113**
	All Ages Combined	355	**220**
HCS	0-20	1,930	**575**
	21+	25,101	**2,321**
	All Ages Combined	27,031	**2,896**

[20] Due to CFC federal income limitations, not all people enrolled in STAR+PLUS HCBS are eligible to receive CFC services. However, the STAR+PLUS HCBS program offers personal assistance services and emergency response services for those persons not eligible for CFC.
[21] An individual was counted as under 21 through the end of the month of their 21st birthday.
[22] Enrollment counts for HCS and TxHmL based on data from the CARE system. Enrollment counts for CLASS and DBMD based on data from SAS system. All counts are unduplicated by client Medicaid number.
[23] CFC utilization counts for CLASS, DBMD, HCS, and TxHmL based on LTSS fee-for-service claims. All counts are unduplicated by client Medicaid number.

Waiver Program	Age Group[21]	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers[22]	Average Monthly Unduplicated Individuals Utilizing CFC Services [23]
TxHmL	0-20	1,365	**956**
	21+	4,726	**2,834**
	All Ages Combined	6,092	**3,790**
All Waivers Combined	**0-20**	**5,132**	**3,122**
	21+	**33,869**	**8,988**
	All Ages Combined	**39,001**	**12,110**

Nursing Facility -Level of Care

The Medically Dependent Children Program (MDCP) is a 1915(c) waiver that provides home and community-based services as an alternative to a nursing facility for children and young adults. The STAR+PLUS HCBS and Dual Demonstration HCBS programs operated through the 1115 waiver provide a cost-effective alternative to living in a nursing facility to older adults or those who have disabilities.

Institution for Mental Disease -Level of Care

Youth Empowerment Services (YES) is a 1915(c) waiver that provides home and community-based services to children as an alternative to an institution for mental disease.

As indicated in Table 3, an average of 10,513 individuals received CFC services each month in fiscal year 2019 across MDCP, YES, STAR+PLUS HCBS, and Dual Demonstration HCBS.

Table 3. Average Monthly Enrollment in LOC Nursing Facility & IMD Waivers by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in Fiscal Year 2019

Program	Age Group[24]	Average Monthly Unduplicated Enrollment[25]	Average monthly Unduplicated Individuals Utilizing CFC Services[26]
MDCP	0-20	5,381	1,566
YES	0-20	1,406	43
STAR+PLUS HCBS	21+	57,313	8,580
Dual Demonstration HCBS	21+	4,133	324
All Waivers Combined	**0-20**	**6,787**	**1,609**
	21+	**61,446**	**8,904**
	All Ages Combined	**68,233**	**10,513**

CFC for All Programs

In fiscal year 2019, an average of 25,331 individuals utilized CFC services each month for all programs including waiver and non-waiver recipients. Of the 25,331, 5,900 were 20 years old or younger and 19,431 were 21 years old or older.

Transition of LTSS to Managed Care

HB 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and outlines two stages for the transition of LTSS. Stage one[27] directs the following activities related to the pilot program:

- Development and implementation of a pilot by September 1, 2023 through the STAR+PLUS Medicaid managed care program for individuals with an IDD, traumatic brain injury or similar functional need to test person-centered managed care strategies and improvements based on capitation;
- Establishment of a SPPPW to assist with developing and advising HHSC on the operation of the pilot program;

[24] An individual was counted as under 21 through the end of the month of their 21st birthday.
[25] Enrollment counts for the YES waiver and all managed care programs based on data from PPS compiled in the CADS 8-month eligibility file. All counts are unduplicated by client Medicaid number.
[26] CFC utilization counts for YES waiver and all managed care programs based on encounter records from the TMHP Vision 21 Enc. Best Picture universe. All counts are unduplicated by client Medicaid number.

[27] Texas Government Code, Chapter 534, SUBCHAPTER C: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm

- Coordination and collaboration throughout development and implementation of the pilot program with the IDD SRAC and the SPPPW; and
- A dental evaluation to determine the most cost-effective dental services for pilot program participants.

Stage two[28] includes development and implementation of a plan to transition all or a portion of services provided through community-based ICF-IID or a Medicaid waiver program to a Medicaid managed care model.

The results of stage one will be used to inform stage two. The program transitions in stage two are staggered beginning with TxHmL in September 2027, CLASS by September 1, 2029, and non-residential HCS and DBMD services by September 1, 2031.

HHSC must conduct a second pilot program to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and community-based ICF/IID services to managed care.

COVID-19 impacted HHSC's timeline and planning efforts to determine the pilot program design for stage one. HHSC is required by statute to collaborate with the IDD SRAC and SPPPW throughout development and implementation of the pilot. All HHSC advisory committee meetings were cancelled March 16, 2020 through May 15, 2020, adhering to federal guidance for social distancing. Additionally, internal pilot program workgroups were paused as HHSC staff focused on pursuing flexibilities in response to the impact of COVID-19 on services and supports for Texans. Pilot program planning meetings with state staff and stakeholders resumed virtually in late May 2020.

HHSC's implementation and planning efforts for stage one to date include:

- Development of a workplan and workgroups comprised of multiple departments across HHSC[29] and cross agency staff, including Texas Workforce Commission, to inform pilot program development.
- Establishment of the SPPPW in February 2020. SPPPW conducted their first meeting on March 10, 2020, and their second meeting on June 17, 2020. SPPPW is increasing meeting frequency to monthly to ensure members are able to provide input on the pilot program design.
- Collaboration with IDD SRAC and SPPPW to inform the pilot program design including but not limited to eligibility criteria, services, and providers. The IDD SRAC shared their initial recommendations for pilot program eligibility, employment assistance and supported employment services, and consumer directed services in the pilot program during the June 17, 2020, SPPPW

[28] Texas Government Code, Chapter 534, SUBCHAPTER E: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm

[29] HHSC departments collaborating in the development, operation and evaluation of the pilot program include: Medicaid CHIP Services, Health Developmental and Independence Services, Intellectual and Developmental Disability and Behavioral Health Services, Access and Eligibility Services, Legal Services, Procurement and Contracting Services, Chief Financial Officer, Office of Policy and Rules, Office of Performance Management, Regulatory Services, Office of the Ombudsman, and HHSC Information Technology.

meeting. Coordination of IDD SRAC and SPPPW recommendations will be ongoing.

- HHSC conducted the dental study to inform dental benefits for pilot program participants. The findings will be shared late fall 2020. The study will inform the advisory committee and workgroup recommendations to HHSC on the dental benefit for the pilot program.

IT Modernization

An exceptional item for IT modernization was funded during the 86th Legislative session to support the future transition of the IDD waiver programs. The first phase of this transition is currently underway with a focus on migrating the HCS and TxHmL program forms and claims processing function from the legacy mainframe system to modern web-based systems. The project is currently undergoing integration testing of the new modernized systems with a goal of implementing the first release late summer of 2021. The release will be supported by provider training through webinars, system user guides and detailed form completion guides.

Planning is underway for a modernized reporting framework that will incorporate the use of a dashboard concept, alerts and standard reports for providers, state staff and local intellectual and developmental disability authorities (LIDDAs). The new web-based, service-oriented systems are utilizing the same technology platforms as other Medicaid management information system (MMIS) systems. Utilizing the existing MMIS will position all four IDD waiver programs for eventual transition of individuals to managed care.

4. Effects on the System

Complaints, Appeals, and Fair Hearings

Complaints, appeals, and state fair hearings data provide information about access to and quality of acute care services following the transition of acute care services to managed care. Complaints are currently filed by contacting a member's MCO, and the HHSC Office of the Ombudsman.

Complaints Data Trending and Analysis Initiative

HHSC has identified opportunities to improve the member and provider managed care complaints process and data collection for all members including members who have IDD. A cross divisional workgroup was formed in July 2018 to address this effort. Activities are in line with the 85th Legislative Session, Rider 61 report recommendations regarding strengthening oversight of the Texas Medicaid program.

The project streamlined the member and provider complaint process; standardized definitions and categorizations of complaints within HHSC and MCOs; improved data analysis to efficiently recognize patterns and promote early issue resolution; and provided greater transparency about complaints.

HHSC reviewed and improved the member complaints process with a no-wrong-door approach to ensure timely assistance. Complaints received by HHSC are now funneled to the Office of the Ombudsman so that every complaint is recorded accurately and reconciled consistently.

Accomplishments completed include:

- Documented the HHS member managed care complaints process, identifying entry points and opportunities to streamline.
- Deployed a new no wrong door complaints process. This involves funneling the majority of member complaints to the Office of the Ombudsman.
- Published the Office of the Ombudsman quarterly complaints report to the HHS website.
- Implemented complaint category standardization across HHSC and MCOs.
- Revised MCO reporting requirements from quarterly to monthly to aid in early issue detection.
- Executed contract changes related to complaints definitions.
  - This includes clarifications that complaints resolved within 24 hours of contact are still considered complaints.
- Deployed client-facing changes to the new member complaints process including a communications plan. The plan includes:
  - How to submit a complaint to the Office of the Ombudsman.
  - Where to seek follow up information on a complaint.
  - The resolution process and associated timelines.

- Deployed provider-facing changes to the provider managed care complaints process.
- An upcoming project milestone is to post complaints data to the HHSC website.

Managed Care Organizations

STAR+PLUS, STAR Kids, and STAR Health MCOs must maintain a system for receiving, tracking, responding to, reviewing, reporting, and resolving complaints regarding services, processes, procedures, and staff. Individuals enrolled in STAR+PLUS, STAR Kids, and STAR Health, or their legally authorized representative (LAR), may file a complaint with their MCO if they are dissatisfied with a matter other than an adverse benefit determination taken by the MCO.[30] Individuals in STAR+PLUS, STAR Kids, and STAR Health, or their LAR, may file an appeal with their MCO if they are dissatisfied with an adverse benefit determination taken by the MCO.

Complaint means an expression of dissatisfaction expressed by a complainant, orally or in writing to the MCO, about any matter related to the MCO other than an adverse benefit determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Complaint includes the member's right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

Complainant's oral or written dissatisfaction with an adverse benefit determination is considered a request for an MCO internal appeal. Table 4 below shows the average monthly number of individuals in an IDD waiver or ICF/IID compared to the number of complaints received in state fiscal year 2019 by managed care program.

[30] An adverse benefit determination means: the denial or limited authorization of a member or provider requested services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial in whole or in part of payment for service; the failure to provide services in a timely manner as determined by the State; the failure of an MCO to act within the timeframes set forth in the contract and 42 C.F.R. §438.408(b); for a resident of a rural area with only one MCO, the denial of a Medicaid members' request to obtain services outside of the Network; or the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Table 4. Average Monthly Number of Individuals in an IDD Waiver or ICF/IID Receiving Services in STAR+PLUS, STAR Kids, and STAR Health and Complaints Received by MCOs from these Members in Fiscal Year 2019 regarding Acute Care

Managed Care Program	Average Monthly Number of Individuals Receiving Services who were in an IDD Waiver or ICF/IID	Number of Complaints Received by Members in an IDD Waiver or ICF/IID in Fiscal Year 2019
STAR+PLUS	16,909	**167**
STAR Kids	4,962	**158**
STAR Health	138	**4**
Total	**22,009**	**329**

The top three reasons for complaints from members in an IDD waiver or ICF/IID in fiscal year 2019 were quality of care or services, accessibility/availability of services, and billing issues. All reasons for complaints in fiscal year 2019 from members in an IDD waiver are listed below.

- Quality of care or services
- Accessibility/availability of services
- Billing issues
- Eligibility
- Durable medical equipment (DME)
- Quality of service practitioner
- Plan administration
- Physical therapy
- Claims processing
- Prior authorization

Table 5. Number of MCO Internal Appeals Upheld, Overturned, or Withdrawn for Recipients in an IDD Waiver or ICF/IID Enrolled in STAR+PLUS, STAR Kids, and STAR Health in Fiscal Year 2019

Program	Total Number of Appeals Filed	Number of Appeals Upheld by MCO[31]	Number of Appeals Overturned by MCO[32]	Number of Appeals Withdrawn by Member
STAR+PLUS	299	156	119	**25**
STAR Kids	382	365	118	**8**
STAR Health	15	10	3	**2**

[31] Indicates that the MCO investigated, reviewed, and ruled in favor of the adverse benefit determination taken by the MCO.
[32] Indicates that the MCO investigated, reviewed, and overturned the adverse benefit determination taken by the MCO.

Program	Total Number of Appeals Filed	Number of Appeals Upheld by MCO[31]	Number of Appeals Overturned by MCO[32]	Number of Appeals Withdrawn by Member
Total	**696**	**531**	**240**	**35**

Only after exhausting the MCO internal appeals process may STAR+PLUS, STAR Kids, and STAR Health members, or their LAR, request a State Fair Hearing by HHSC.

The top three reasons for State Fair Hearings in fiscal year 2019 for members enrolled in an IDD waiver or ICF/IID related to reduction or denial of DME, Private Duty Nursing, and therapy. All reasons for State Fair Hearings in 2019 for members enrolled in an IDD waiver related to reduction or denial of services and supports are listed below.

- DME
- Therapy – Treatment
- Private duty nursing
- MRI
- Pharmacy
- Inpatient

Office of the Ombudsman

The Office of the Ombudsman received 56 complaints, 5 substantiated[33] and 51 unsubstantiated[34] or unable to substantiate[3], in fiscal year 2019 for STAR+PLUS, STAR Kids, and STAR Health members enrolled in an IDD waiver. Access to DME, Access to long-term services and supports (LTSS), and Access to Prescriptions were the top complaints. All complaint reasons received are listed below.

- Access to Dental Services (adult)
- Access to DME
- Access to In-Network Provider (non-PCP)
- Access to LTSS
- Access to Out-of-Network Provider
- Authorization issue
- Denial of Services
- Disagree with Policy
- Prescription Services - Medicare
- Prescription Services - Member not showing active
- Prescription Services - non-Medicaid provider

[33] Substantiated complaint--A complaint for which research clearly indicates HHS policy was violated or HHS expectations were not met.
[34] Unsubstantiated complaint--A complaint for which research clearly indicates HHS policy was not violated or HHS expectations were met.
[3] Unable to substantiate complaint--A complaint for which research does not clearly indicates HHS policy was violated or HHS expectations were not met.

- Prescription Services - Other insurance
- Reduction/Suspension/Termination of Services
- Service Coordination/Service Management
- Staff Behavior
- Therapy – Availability of Services
- Therapy – Denial of Authorization
- Therapy – Lack of Occupational Therapy Provider
- Therapy – Lack of Physical Therapy Provider

5. Initiatives to Improve Access and Outcomes

Person-Centered Planning

Federal rules for all Medicaid HCBS, including CFC, require person-centered service planning, also referred to as person-centered planning (PCP). Using a PCP process, a service plan and objectives are developed based on a person's preferences, strengths, and clinical and support needs. Person-centeredness balances what is important for the person's health and safety with what is important to the person for their well-being and quality of life. Person-centered service planning considers non-clinical concepts such as self-determination, dignity, community inclusion, and the belief that every person is the expert in their own life, has the potential for a personally defined high quality life, and can meaningfully contribute to society.

To comply with federal and state regulations, HHSC requires people who facilitate person-centered service plans for CFC and HCBS to complete training within six months of hire, as of September 1, 2019. The state and its partners, including LIDDAs, The University of Texas Center for Disability Studies, and The Learning Community for Person-Centered Practices (TLCPCP), have been working to build the infrastructure to successfully comply by training more certified Person-Centered Thinking (PCT) trainers.

Training

There is a total of 19 certified PCT trainers who were trained on behalf of the state. The state has supported employees of LIDDAs, Councils of Governments, Managed Care Organizations (MCOs) and provider agencies in becoming PCT Trainers.

Through the Money Follows the Person Demonstration (MFPD) grant funding, two HHSC staff and one private provider staff became certified PCT Mentor Trainers in December 2018. The two HHSC certified PCT Mentor Trainers were certified as PCT Coaching Trainers in October 2017. The MFPD grant funded an initiative to certify six People Planning Together (PPT) co-facilitators who receive services for IDD. PPT co-facilitators with lived experience partner with a PCT trainer to train people with IDD to create their own person-centered plans and better communicate and partner with service providers. In the past four years, more than 1,936 service coordinators and case managers from LIDDAs, MCOs, and private providers have completed a two-day face-to-face PCT Training. This training continues to be offered in collaboration with community partners.

Overviews of person-centered practices have been provided to various groups, including potential and current providers for the Consumer Directed Services (CDS) option for service delivery, CLASS, and DBMD services, and at conferences upon request. As of July 8, 2020, 7,678 people, including people from other states, had successfully completed the online PCP Training that launched in February 2017. The free training is accessible at: https://hhs.texas.gov/services/disability/person-

centered-planning/person-centered-planning-waiver-program-providers/person-centered-planning-pcp-training-providers.

PCT training continues to expand to other state staff, such as social workers and case managers, Child Protective Services (CPS) employees, and now nursing staff within utilization review teams. PCT training also continues to be offered at nursing facilities across the state. PCT Coaching training began in 2019, with both in person and webinar sessions. PCT Coaches participate in a six-month mentored process and learn how to provide informal training and support others within their organizations to identify naturally occurring opportunities to practice and improve PCT skills. PCT Coaching is meant to help embed person-centeredness within the operation of any organization.

Other Initiatives

In March 2019, HHSC was awarded one of 15 three-year technical assistance grants by the National Center on Advancement of Person-Centered Practices and Systems (NCAPPS) to align policy and practice across the state for all populations across the lifespan.

As of February 28, 2020, HHSC had established a PCP Steering Committee and the draft of a strategic plan to ensure person-centered thinking, planning, and practice occurs throughout the HHSC system. By December 2022, HHSC will have created a PCP framework and accompanying tools, guidance, rules, policies and procedures, including adaptations for use with all HHSC populations. (See Appendix C: NCAPPS Texas Technical Assistance Plan)

IDD Assessment Tool Pilot

Texas Health and Safety Code, Section 533A.0335 directs HHSC to develop and implement a comprehensive assessment instrument and resource allocation process to ensure individuals with IDD receive the type, intensity, and range of appropriate and available services to meet their functional needs. The IDD assessment tool pilot project focused on individuals receiving services under IDD Medicaid waivers, community-based ICFs/IID, and SSLCs. Initial planning activities for the pilot included:

- Research into nationally-recognized comprehensive assessment instruments for individuals with IDD;
- Completion of an external stakeholder survey;
- Interviews with other states about assessment instruments; and
- Solicitation of input from the IDD SRAC and its Assessment Subcommittee.

HHSC selected the International Resident Assessment Instrument Intellectual Disability (interRAI ID) Assessment System to pilot with a sample population to determine appropriateness for use in Texas. The IDD assessment tool pilot project will test and evaluate the tool in three phases across Texas IDD waiver programs:

- Phase 1: This phase began in spring 2017 and included automating and piloting interRAI with a volunteer sample. Phase 1 was completed on August 31, 2017.

- Phase 2: This phase included the evaluation and comparison of the interRAI with the currently used assessment, the Inventory for Client and Agency Planning (ICAP). Phase II was completed in December 2018, with the final report received in late February 2019. The results will inform the determination of the appropriateness of statewide implementation.
- Phase 3: HHSC is considering the results from Phase II and will work with external stakeholders and the Legislature on any Phase III activities, which would involve developing a resource allocation process. It is expected that development of the resource algorithm would take up to a year to complete. As implementation of the assessment and resource allocation process is subject to available funding, HHSC would require an appropriation from the Legislature to move forward with Phase III.

The IDD SRAC and HHSC are exploring possible opportunities to utilize the interRAI with the HB 4533 pilot program.

Home and Community-Based Services Settings Requirements

In March 2014, federal regulations became effective governing HCBS settings and laying out expectations for states' implementation of person-centered service planning. The regulations support individuals' rights to:

- Privacy, dignity, and respect;
- Community integration;
- Competitive employment; and
- Individual choice concerning daily activities, physical environment, and social interaction.

States must comply with these rules by March 2023, which includes a one-year extension due to the COVID-19 pandemic.

- In the 2020-21 General Appropriations Act, HB 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 21), the Texas Legislature directed HHSC to develop a plan to replace current day habilitation services in waiver programs for individuals with IDD with more integrated services. HHSC must submit a plan to state leadership by January 1, 2021 for approval.
- States are required to file a Statewide Transition Plan (STP) with Centers for Medicare and Medicaid Services (CMS) which provides assurances of compliance or sets forth the actions that the state will take to bring HCBS programs into compliance. HHSC is revising the STP for submission based on feedback from CMS. HHSC submitted the STP again summer 2020.

IDD Strategic Plan

Texas identified the need to develop a Statewide IDD Strategic Plan to unify state agency leaders and stakeholders to identify and prioritize goals and make improvements in the IDD system. The framework used to develop the IDD Strategic

Plan is modeled after the successful coordination and unified approach of the Texas Statewide Behavioral Health Strategic Plan.

HHSC, in collaboration with state agency leaders and stakeholders, developed and published the Foundation of the Statewide IDD Strategic Plan in February 2019. The foundational plan includes the following:

- Overview of the IDD population, a history of services and supports, and prevalence data;
- Statewide IDD survey and stakeholder input results; and
- IDD Program Inventory.

During the second phase of the process, HHSC and stakeholders further explored community needs and collaborated to develop a comprehensive, multi-sectoral strategic plan. The comprehensive plan includes the following:

- Updated overview of the IDD population;
- New statewide survey and stakeholder input results; and
- Vision, mission, goals, objectives, and strategies to make short- and long-term improvements in IDD-related services, supports, systems, and policies.

The third phase will include implementation and monitoring of the plan.

Rider 42 Interest List Study

2020-21 General Appropriations Act, HB 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 42), directs HHSC to work in consultation and collaboration with the IDD SRAC to conduct a study of the interest lists and develop strategies to eliminate the interest lists for STAR+PLUS HCBS and the HCS, CLASS, DBMD, MDCP, and TxHmL waivers.

As part of the study, HHSC obtained information on the experiences of other states in reducing or eliminating interest lists, identified factors that have affected the interest lists for the five most recent biennia, and gathered existing data on persons on the interest list for each waiver program. Based on the information obtained for the study, HHSC offered strategies and cost estimates for eliminating the interest list for each program. A report with the results of the study was due by September 1, 2020, to the governor and the Legislative Budget Board[35]. Additionally, HHSC is required to update the Statewide IDD Strategic Plan to include the strategies identified in the interest list report.

[35] Medicaid Waiver Interest List Study- Rider 42

6. Promoting Independence and Preventing Institutionalization

Money Follows the Person Demonstration (MFPD)

MFPD is a federal demonstration project designed to increase the use of home and community-based services and to reduce the use of institutional-based services.[36] In August 2019, the President signed the Sustaining Excellence in Medicaid Act of 2019 (Public Law 116-39). Specifically, the Act increases appropriations for the Money Follows the Person Rebalancing (MFP) Demonstration Program to $245.5M, across all 44 MFPD states, and extends the program through Federal Fiscal Year 2024.

The following is a summary of the MFPD-funded projects in Texas designed to promote independence for individuals with IDD.

Integrated and Competitive Employment

"Employment First" is an approach to facilitating the full inclusion of individuals with disabilities in the workplace. Under this approach, integrated, competitive employment should be the first option considered for individuals with disabilities and should be the expected outcome of education and publicly-funded services for working-age youth and adults. Where we work is often where we make friends, demonstrate our abilities, and earn enough disposable income to enjoy other opportunities. Individuals with disabilities are much less likely to have a job than individuals without disabilities.[37]

In 2018, HHSC began offering regional trainings which focus on sharing the Employment First principles; educating providers, family members, and program participants about the employment services currently provided in waiver programs; and addressing the misconception that working will cause program participants to lose their benefits. These regional trainings are funded by MFPD and continued through Fall 2019.

In addition to the regional trainings, HHSC has several other employment initiatives funded through MFPD.

- Employment Recruitment Coordinator – The Employment Recruitment Coordinator furthers the state's Employment First principles with continued field work across the state, directly working with employers and presenting to civic organizations to expand awareness and generate additional integrated employment opportunities for persons with disabilities.

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[36] https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project

[37] American Psychology Association. Disability & Socioeconomic Status. Retrieved June 26, 2020 from: https://www.apa.org/pi/ses/resources/publications/disability

- Employment First Coordinators - Employment First Coordinators assist with the implementation of the HHSC Supported Employment Initiative[38] and conduct other activities as necessary to improve employment services for individuals with developmental disabilities served by HHSC.
- HHSC Employment First Webpage – A HHSC webpage serves as a resource for individuals with disabilities seeking employment information and employers who are seeking to hire persons with disabilities. In fiscal year 2019, the page was viewed 15,513 times, of which 11,125 were unique, distinct views. https://hhs.texas.gov/services/disability/employment/employment-first
- HHSC Employment Services Web-based Trainings – A twelve-module training series that provides an overview of waiver employment services and a Supplemental Security Income/Social Security Disability Insurance benefits overview. In fiscal year 2019, the training was viewed 328 times, of which 305 were unique, distinct views. https://hhs.texas.gov/doing-business-hhs/provider-training/training-initiatives
- Hiring People with Disabilities Video – Developed in 2016, this video targets employers and provides information related to the benefits of hiring persons with disabilities. As of July 2020, this video has been viewed by more than 17,500 people. https://www.youtube.com/watch?v=68ns6xDD16w
- Supporting Employment Goals for People with Disabilities Video – Developed in February 2020, this video targets program participants and families showcases success stories of persons with disabilities achieving integrated, community-based work. As of July 2020, this video has 809 views. This video is in the process of being added to the HHSC Employment First webpage. https://www.youtube.com/watch?v=osIfXHLPOuE
- Employment for People with Disabilities – What You Need to Know brochure – This brochure was developed for people with a disability who want to learn about competitive, integrated employment in the community. The brochure contains information on Employment First, the employment services offered through Health and Human Services programs and how going to work may affect Social Security benefits and health care coverage. The brochure is located on the HHSC Employment First Webpage. https://hhs.texas.gov/services/disability/employment/employment-first

Transition Support Teams

Transition Support teams help community providers and LIDDAs deliver adequate support to individuals with significant medical, behavioral, and psychiatric challenges transitioning from institutional settings or who are at risk of admission to an institution. Eight LIDDAs and community provider consultative support teams

[38]HHSC supportive employment initiatives assist with the promotion and utilization of community-based services, as opposed to institutional-based services, and will assist with the transition into community life activities for participants departing institutional settings. The initiatives involve working with civic organizations, employers, providers and other agencies to increase integrated employment opportunities for people with disabilities.

provide educational activities and materials, technical assistance, and consultative case reviews.

From September 1, 2018, through August 31, 2019, the teams provided:

- 1,495 educational opportunities and 9,992 LIDDA employees and contractors attended.
- 1,550 opportunities for technical assistance and 3,951 employees/contractors attended.
- 445 peer review/case consultations and 1,991 employees/contractors attended.

Enhanced Community Coordination

The LIDDA Enhanced Community Coordination (ECC) service coordinators provide intense monitoring and flexible support to individuals to support success in the community. The ECC service coordinator ensures individuals are linked to critical services and receive person-centered services for up to one year following a transition or diversion. From September 1, 2018, through August 31, 2019, 2,900 people received enhanced community coordination.

Transition Specialists in the State Supported Living Centers

MFPD funds transition specialists and a continuity of services specialist at the State Supported Living Centers (SSLCs). Transition specialists employed at the SSLCs provide training to SSLC staff, residents, LARs, and family members about the community relocation process and planning. They also serve as a resource for personal support teams to help identify services and supports for individuals in the community, to identify obstacles to community transition, and to develop strategies to mitigate barriers. The continuity of services specialist monitors the final community living discharge plan (CLDP) and post-move support to assure quality and make suggestions for improvement. From September 2019 through February 2020, there have been 42 transitions from SSLCs to community settings.

Mental Health Wellness for Individuals with IDD

In December 2017, the State of Texas contracted with University of Texas Health Science Center at San Antonio to develop web-based training modules to educate health care practitioners on best practices in treating individuals with IDD and behavioral health needs. Initial topics included trauma-informed care, the importance of interdisciplinary team work, and communicating with people with IDD and co-occurring behavioral health needs.

In February 2019, with funding from MFPD, HHSC launched three additional modules featuring integrated approaches for working with people who have IDD and co-occurring behavioral health challenges. The new modules expand the knowledge and skills of healthcare professionals including physicians, physician assistants, and nurse practitioners by discussing evidence-based techniques to improve the delivery of health care to individuals with IDD, maximize outcomes, and enhance quality of life.

The project also includes expanding the existing website to include continuing education credits for licensed professional counselors, licensed marriage and family therapists, licensed social workers, peer support specialists and licensed psychology professionals.[39]

The Trauma Informed Care module is required for new employees of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF's/IID) and related conditions. In fiscal year 2019, MHW-IDD modules completions totaled 21,932. The ongoing project includes periodic training enhancements and evaluation data management.

Crisis Intervention and Crisis Respite Services

Initially, the 84th Legislature, Regular Session, 2015 allocated $18.6 million, which increased by $10.0 million over subsequent sessions. A total of $28.6 million has been allocated to provide crisis intervention and crisis respite support to individuals with IDD who have behavioral health or mental health support needs. All 39 LIDDAs statewide provide crisis intervention and crisis respite services to support individuals to maintain independent lives in the community, and to avoid unnecessary institutionalization. From September 1, 2018, through August 31, 2019:

- 2,746 individuals were served in crisis intervention services,
- 585 received crisis respite services,
- 971 individuals went to a psychiatric hospital,
- 335 went to a jail,
- 334 went to a hospital, and
- 302 went to other facilities.

Housing Initiatives

Affordable Housing Partnership

The Affordable Housing Partnership (AHP) is a new collaboration between HHSC and the Texas State Affordable Housing Corporation (TSAHC) to provide capital subsidies to developers to build or rehabilitate housing units as affordable, accessible and integrated housing units within Dallas and Travis Counties for qualified individuals receiving or eligible for Medicaid LTSS in the community. It is anticipated the project will result in 30 new units for individuals with disabilities. Priority for available units will be designated for individuals transitioning into their communities from nursing facilities or ICFs/IID. HHSC and TSAHC will work in partnership to implement and administer the AHP to increase the availability of affordable, accessible and integrated housing for older adults and people with disabilities.

[39] www.mhwidd.com

Texas Department of Housing and Community Affairs 811 Project Rental Assistance

The Section 811 Project Rental Assistance (PRA) Program is a project-based, federally-funded program that allows state Housing Finance Agencies (such as TDHCA) and state Medicaid Agency partners (such as Texas HHSC) to create rental assistance opportunities for persons with extremely low incomes who have a disability and are eligible to receive services and supports. Money Follows the Person Demonstration funding support this housing effort. Texas' Section 811 PRA serves the following target populations:

- Persons with disabilities exiting institutions (e.g., nursing facilities and ICF/IID), who are eligible to receive long-term services and supports through a Medicaid waiver;
- persons with SMI who are eligible to receive services through HHSC; and
- Youth or young adults with disabilities exiting DFPS foster care.

Section 811 PRA is limited to select areas of the state. Only properties located in the following Metropolitan Statistical Areas are eligible to participate in the program:

- Austin-Round Rock
- Brownsville-Harlingen
- Corpus Christi
- Dallas-Fort Worth-Arlington
- El Paso
- Houston-The Woodlands-Sugar Land
- McAllen-Edinburg-Mission
- San Antonio-New Braunfels

As of December 2019, the 811 PRA program housed 380 people, referred 3,024 people, and engaged 148 participating properties.

7. IDD System Redesign Advisory Committee

The IDD SRAC collaborates with HHSC on the IDD acute care and LTSS system redesign by providing recommendations and identifying areas for improvement. The advisory committee consists of 26 members representing communities of interest as identified in Texas Government Code, Section 534.053. IDD SRAC subcommittees include:

- Transition to Managed Care
- Day Habilitation and Employment Services
- System Adequacy

IDD SRAC meets quarterly and subcommittees meet bi-monthly. However, due to their focus on the development of recommendations for Legislative initiatives from the 86th session and meeting cancellations due to COVID-19 and federal guidance for social distancing, the IDD SRAC plans to meet monthly for both full committee meetings and subcommittee meetings through December 2020.

IDD SRAC priorities from the 86th session include the HB 4533 Pilot Program and Rider 42 Interest List Study. Since passage of HB 4533, IDD SRAC members worked with HHSC to organize requirements for the pilot program and prioritize subcommittee work based on the project timeline. The IDD SRAC also partnered with the SPPPW to coordinate recommendations and work collaboratively to inform the pilot program. The IDD SRAC System Adequacy subcommittee worked with HHSC to develop recommendations to be included in the Rider 42 Interest List Study. System Adequacy recommendations were presented to the full IDD SRAC for review and adoption in June 2020.

Many IDD SRAC recommendations require a multi-year focus due to required funding and the complexity of policy and system changes recommended (see Appendix A: IDD System Redesign Advisory Committee Legislative Appropriations Request Recommendations for State Fiscal Year 2022-2023 and Appendix B: IDD SRAC Recommendations). During fiscal year 2020, in addition to work on the HB 4533 Pilot Program and Rider 42 Interest List Study, IDD SRAC worked to enhance and build upon recommendations, major achievements, and areas of focus, including:

- addressing barriers to transition IDD LTSS to managed care;
- improving quality and continuity of services and supports;
- increasing independence and community inclusion; and
- addressing barriers to system adequacy including rates, interest list allocation, and network adequacy. Challenges and Areas for Further Consideration

HHSC and stakeholders have identified opportunities to improve the current system of services and supports for people with IDD. Many of these challenges and considerations are being prioritized by IDD SRAC subcommittees for the upcoming year. Some of them may require funding or staff resources to implement.

Transition of IDD LTSS to Managed Care

HB 4533 provides additional time to transition IDD LTSS to managed care and a structure for robust stakeholder engagement through the IDD SRAC and SPPPW. HHSC will work with stakeholders to ensure challenges are addressed through development and implementation of the pilot program and subsequent transitions of IDD LTSS to managed care. HHSC is working with stakeholders to assess and account for any potential considerations related to COVID-19 and its impact on the STAR+PLUS Pilot Program and IDD LTSS transition.

Person-Centered Practices

A lack of understanding of benefits and the PCP process was previously identified and continues to be a barrier to achieving more person-centered outcomes for people receiving Medicaid waiver services. The current People Planning Together initiative, together with additional systemic improvements that will be part of the NCAPPS activities, is expected to help to continue to address these challenges.

PCP experts are working to develop training to support people hospitalized with the COVID-19 illness. The 2-part virtual training series will provide an overview of Person-Centered Thinking, a brief "snapshot" of medical information needed, and how best to support the person during any medical procedures, including how to develop a one-page description for the person. The virtual training addresses the fear and stress related to a medical crisis or emergency. The one-page description will provide medical staff critical information on how to support the person to be calm, comforted and feel safe.

Quality Metrics

Further work is needed to identify quality metrics to measure outcomes of health initiatives that address acute care health needs common to individuals with IDD. The IDD SRAC drafted recommendations on ways to review, analyze and monitor quality metrics for consideration.

Attendant Workforce

A successful community-based long-term care system is contingent upon a stable and trained workforce. According to the U.S. Bureau of Labor Statistics (BLS), personal care aides (PCAs) and home health aides (HHAs) forecasted to be the third and fourth fastest growing occupations in the country from 2016-2026 with ten-year projected growth rates of 47 percent and 39 percent, respectively. Meanwhile, as the Baby Boomer generation and informal caregivers age, the number of Americans requiring long-term care is projected to more than double by 2050, creating greater demand for paid attendant services in the coming decades. As of May 2018, Texas employed 206,240 PCAs, the second largest statewide number in the country.[40] While demand for direct care workers both in Texas and nationwide

[40] https://phinational.org/policy-research/workforce-data-center/ last modified August 30, 2019.

continues to increase exponentially, long-term care employers are already struggling to hire and retain direct care workers.

The 2020-21 General Appropriations Act, HB 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157) directs HHSC to develop strategies to recruit, retain, and ensure adequate access to the services of community attendants. The work of Rider 157 resulted in a state workforce strategic plan for retention and recruitment of community attendants. More specifically, HHSC explored innovative ideas for recruitment and retention of community attendants. HHSC convened a group of stakeholders to inform the creation of the strategic plan. Workforce development and fostering local community partners was a key theme. Partnerships with community colleges, training programs and local workforce development boards assist in retaining workers and supporting them to have the needed training. Training in general increases employee job satisfaction, motivation, and morale.

In addition to training, stakeholders also raised other challenges to be addressed in the long-term strategic plan including attendant wages and improving data collection on recruitment and retention. This strategic plan will serve as the framework for more specific strategies to recruit and retain formal caregivers.

CFC

Many individuals not enrolled in an IDD waiver may be eligible for or receiving CFC services. To ensure that everyone entitled to receive CFC services is able to access them, improved data is needed to track CFC services when they are authorized and provided for individuals with IDD who are receiving managed care services and are not enrolled in an IDD waiver. HHSC recently implemented a method to improve the accuracy of CFC non-waiver utilization data and going forward will provide more reliable statistics. HHSC is considering options to increase the accessibility and utilization of CFC services, including:

- Offering additional training to MCOs and providers on how to assess for, provide and bill for CFC;
- Developing a plan to target and assess individuals with IDD currently on an IDD waiver interest list;
- Exploring how to best move forward with the assessment of CFC services; and
- Introducing habilitation training for providers who have not previously provided services for individuals with IDD.

IDD Assessment Pilot

The timing of the IDD LTSS carve-ins was adjusted by HB 4533 and will begin September 1, 2027. However, the implementation date for Phase 3 of the assessment pilot and statewide implementation of the new assessment has not yet been determined. Use of the interRAI as the assessment tool for the future IDD LTSS transitions to managed care has not been determined. The HB 4533 pilot program may provide an opportunity for an additional limited roll-out of the interRAI.

8. Conclusion

HHSC has made significant progress on the IDD system redesign. With the passage of HB 4533, outstanding tasks required by statute were amended and now allow time to pilot LTSS in managed care before the transition. Opportunities exist for systemic improvement, as outlined in the previous section and appendices of this report, and as expressed by members of the IDD SRAC and other stakeholders. HHSC is committed to continuing to work with stakeholders to improve programs and services for Texans with IDD.

Milestones

- 2014-2016 HHSC transitioned acute care services in STAR+PLUS and STAR Kids to managed care for eligible individuals with IDD.
- 2015 the CFC option was implemented in Texas to increase access to services for individuals with IDD, particularly those currently on interest lists for IDD waiver programs.
- 2014-present increased and enhanced community support services to promote independence and prevent institutionalization of individuals with IDD.
- 2019 deployed a new no wrong door complaints process to funnel the majority of member complaints to the Office of the Ombudsman; implemented complaint standardization across HHSC and MCOs; and revised MCO reporting requirements from quarterly to monthly to aid in early issue detection.
- 2019-2020 developed a workplan and workgroups comprised of cross agency state staff to inform pilot program development; collaborated with IDD SRAC to inform the pilot program design including eligibility criteria, services, and providers; and established SPPPW and collaborated with both the IDD SRAC and SPPPW.

Next Steps

- Continue efforts to design, implement and evaluate the pilot program, including coordination with the IDD SRAC and SPPPW.
- Finalize the dental study to inform the dental benefit in the pilot.
- Continue efforts to simplify and streamline the member managed care complaints process and data collection.
- Continue to collaborate with IDD SRAC to assess access to IDD services and supports and review outcomes related to transitioning acute care services to managed care and implementing CFC.
- Monitor new method for obtaining CFC non-waiver utilization data and consider options to improve the accessibility and utilization of CFC services.

Appendix A. List of Acronyms

Acronym	Full Name
CAHPS	Consumer Assessment of Healthcare Providers and Services
CDS	Consumer-Directed Services
CFC	Community First Choice Option
C.F.R.	Centers for Medicaid & Medicare Services Code of Federal Regulations
CLASS	Community Living Assistance and Support Services
CLDP	Community Living Discharge Plan
CMS	Centers for Medicare & Medicaid
COC	Continuity of Care
COVID-19	Coronavirus disease 2019
CCSSLC	Corpus Christi State Supported Living Center
CPS	Child Protective Services
DADS	Department of Aging and Disability Services
DBMD	Deaf Blind with Multiple Disabilities
DFPS	Department of Family and Protective Services
DME	Durable Medical Equipment
DSHS	Department of State Health Services
ECC	Enhanced Community Coordination
EQRO	External Quality Review Organization
FFS	Fee-for-service
HB 4533	House Bill 4533
HCBS	Home and Community-Based Services
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
HPM	Health Plan Management
IAP	Innovation Accelerator Program
ICF	Intermediate Care Facility
ICF/IID	Intermediate Care Facility for an Individual with an Intellectual Disability

Acronym	Full Name
IDD	Intellectual and Developmental Disabilities
IDD SRAC	Intellectual and Developmental Disabilities System Redesign Advisory Committee
interRAI ID	International Resident Assessment Instrument Intellectual Disability Assessment
LAR	Legally Authorized Representative
LIDDA	Local Intellectual and Developmental Disability Authority
LTSS	Long-Term Services and Supports
MCCO	Managed Care Compliance and Operation
MCO	Managed Care Organization
MCOT	Mobile Crisis Outreach Team
MDCP	Medically Dependent Children Program
MFP	Money Follows the Person
MFPD	Money Follows the Person Demonstration
MHW-IDD	Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities
MMIS	Medicaid Management Information System
NASHP	National Academy for State Health Policy
NCAPPS	National Center on Advancement of Person-Centered Practices and Systems
NCAPPS TA	NCAPPS Technical Assistance
NSCH	National Survey of Children's Health
PCS	Personal Care Services
PCP	Person-Centered Planning
PCT	Person-Centered Thinking
PPE	Potentially Preventable Event
PPT	People Planning Together
PRA	Project Rental Assistance Program
PPV	Potentially Preventable Emergency Department Visit
SAS	Service Authorization System
SPPPW	STAR+PLUS Pilot Program Workgroup
SSAS	Single Service Authorization System

Acronym	Full Name
SSI	Supplemental Security Income
SSLC	State Supported Living Center
STP	State Transition Plan
TLCPCP	The Learning Community for Person-Centered Practices
TMHP	Texas Medicaid & Healthcare Partnership
TWC	Texas Workforce Commission
TxHmL	Texas Home Living
UM	Utilization Management
UR	Utilization Review

Appendix B. IDD System Redesign Advisory Committee Legislative Appropriations Request Recommendations for State Fiscal Year 2022-23

Transition to Managed Care Subcommittee

Topic: Records and Data Systems

Overview / Background

Currently, the system used by the state for billing and payment, service coordination and critical incident reporting is either outdated — Home and Community-based Services (HCS) waiver CARE system — or paper-based, as in Community Living Assistance and Support Services (CLASS) & Deaf Blind with Multiple Disabilities (DBMD). Therefore, substantial administrative time is spent by HHSC, service coordinators and providers in the exchange of information that could be seamlessly shared electronically. Systems currently operated in the fee-for-service (FFS) program are also not interoperable with managed care organization systems creating barriers to the vision of a more streamlined acute and long-term care service delivery system.

Using outdated systems includes other repercussions, as well, including:

- Difficulty gathering and analyzing useful, trend-able data related to quality
- Additional regulatory time spent on-site analyzing information
- Use of fax or mail as a means of communication rather than encrypted emails
- Reduction in direct service time by service coordinators and provider due to time spend on transferring documentation
- Delays in processing and implementing plans of care and Medicaid eligibility due to human error
- Difficulty sharing information and coordinating care between entities caring for persons with IDD
- Increased risk for HIPAA non-compliance

With the transition to managed care, managed care organizations (MCOs) would benefit from more seamless data sharing.

Use of electronic life/electronic health records for long-term services and supports (LTSS) programs will improve the quality of the programs, provide the state better data on the quality of programs, streamline communications and processes for eligibility and implementation of services, reduce administrative burdens of agency staff, service coordination staff, LTSS provider staff and MCO staff, and improve the quality of services delivered in the community.

Proposed Solution

The state must develop the capability to electronically maintain health and life records for all individuals served in LTSS programs that are interoperable with related systems.

Electronic Life Record/Electronic Health Record providers currently on the market include basic health and life records, as well as additional modules that improve provider quality assurance through online staff training specific to individuals, critical incident reporting data trending, and immediate notifications to nursing staff of potential errors by delegated staff.

Life records should be available to consumers, MCOs and all parties involved and be on a shared platform.

Request / Recommended Course of Action

Contract with an experienced vendor to replace other record management systems with a unified platform for the use of electronic health/electronic life record technology. The selected system must be capable of interoperability between MCOs, service coordinators, and long-term care providers.

Require and fund the use of electronic documentation by long-term care service providers.

Topic: Expanding Physician Capacity

Overview / Background

Individuals with intellectual and developmental disabilities (IDD), as a group, are living longer and need the opportunity to age well. In addition, children and adults with IDD often have difficulties finding a medical home that understands their unique needs. A few exceptional clinics have been developed in Texas to address these needs. Examples include The Baylor Transition Clinic and the Dell Children's Comprehensive Clinic Both clinics look at children or adults with disabilities on a more comprehensive basis and have expertise in treating persons with multiple conditions. Based on information and testimony presented in the STAR Kids Advisory Committee, these types of clinics have very favorable outcomes and should be considered as models with best practices for persons with intellectual and developmental disabilities. These clinics have proven better outcomes for children and adults with IDD.

Proposed Solution

The IDD SRAC recommends the legislature appropriate additional funding to cover the additional costs of directed payment programs for comprehensive care and transition clinics. Clinics must meet HHSC-defined criteria and contract with Medicaid managed care organizations. Funding should be sufficient to provide access to persons with IDD and ensure the expertise to treat complex conditions for persons with multiple conditions.

Some areas in Texas are interested in developing these types of specialty clinics, but lack adequate funding. Funding should be provided to expand these programs in other major metropolitan areas. This proposal is for an exceptional funding item request to continue funding the current programs and expand these clinics throughout the state of Texas.

Request / Recommended Course of Action

Expand physician and specialty capacity for persons with intellectual and developmental disabilities through adding funding of comprehensive care clinics and transition clinics.

- Direct HHSC to determine qualification standards for comprehensive and transition clinics.
- Include funding recommendations as described above.

Topic: Fund HB 4533 Pilot Development

Overview / Background

Senate Bill 7, 83rd Legislative Regular Session, created Chapter 534, Texas Government Code calling for the design of an acute care and long-term services and supports (LTSS) system for persons with IDD under the Medicaid managed care program Senate Bill 7 authorized the Health and Human Services Commission (HHSC) to develop and implement a pilot to test managed care strategies for IDD LTSS service delivery.

After developing and procuring the pilot, HHSC terminated implementation in September 2017 in response to identified operational barriers, including concerns from the Centers for Medicare and Medicaid (CMS). In absence of a pilot, the legislatively mandated IDD System Redesign Advisory Committee (SRAC) determined the state did not have the legislatively required evaluative cost or quality data to inform decisions about a transition of all or a portion of IDD LTSS into managed care.

In response to the above concerns, HHSC engaged Deloitte Consulting LLP (Deloitte) to evaluate cost impact of transitioning IDD LTSS to managed care and The University of Texas Health Science Center at Houston, School of Public Health (UTHealth) to research IDD service delivery models in other states and to conduct field studies with key Texas stakeholders. While the HHSC-commissioned evaluations by Deloitte and UTHealth were underway, the IDD SRAC continued its statutory responsibilities by conducting an in-depth analysis and consideration of the transition of all or a portion of IDD waiver services to managed care. This analysis, coupled with the final reports issued by Deloitte and UTHealth, revealed substantial readiness concerns, including concerns about the comprehensive assessment tool and corresponding resource allocation methodology, also directed by Senate Bill 7 (2013) and, among other conclusions, recommended development of a pilot within the managed care structure that did not affect the current IDD waivers and a slow, phased-in approach to transitioning the waiver programs with minimal disruption to services.

The outcome of the aforementioned reports and recommendations resulted in amendments to Chapter 534, Texas Government Code by the 86th Texas Legislature via HB 4533, calling for HHSC, in consultation and coordination with the IDD SRAC and newly established Pilot Program Workgroup, to develop and implement a pilot to test, through the STAR+PLUS Medicaid managed care program, the delivery of

long term services and supports to persons with IDD or with similar functional needs.

The Pilot Program must implement by September 1, 2023, operate for at least 24 months and include a comprehensive evaluation to determine the feasibility of transitioning all or a portion of the IDD long-term services and supports to the Texas Medicaid managed care program.

The 86th Legislature did not provide funding for the Pilot Program or for administrative and systems costs associated with preparation of the Pilot Program. While the 88th Legislature will need to appropriate funds to conduct the Pilot Program, the 87th Legislature will need to appropriate funds to address HHSC administrative and systems costs related to preparing for the pilot.

Request / Recommended Course of Action

Funds to support preparation for implementation of the IDD managed care pilot program. Though not inclusive funds are needed to address development and requisite infrastructure requiring IT and systems modifications, eligibility and or assessment, public outreach and education, full time employees and contracts for statutorily required evaluations.

The funds are needed to ensure the pilot is operational by September 1, 2023.

The Pilot Program will develop processes to:

- Ensure the state has sufficient and valid information to inform the final stage of the IDD LTSS system redesign called for in Chapter 534, Texas Government Code.
- Ensure the best possible outcomes for individuals with IDD and those with similar functional needs in accordance with the system redesign goals specified in Chapter 534, Texas Government Code.
- Ensure the most effective and efficient use of Medicaid resources, a tenet of Chapter 534, Texas Government Code.
- Ensure development of a system redesign in coordination with and input from all affected stakeholders.

System Adequacy Subcommittee

Topic: Training and Skill Development in CDS Option

Overview / Background

Enhanced Training and Ongoing Skill Development for Consumer-Directed Services (CDS) and Non-CDS Attendants and CDS Employers.

CDS and Non-CDS Attendants: While funds for competitive and appropriate wages and benefits is an important factor, it is only one of numerous factors that impact long standing challenges with attendant recruitment and retention in delivering LTSS to individuals with IDD and other disabilities. The ability to offer enhanced training and ongoing skill development, including habilitation training, are equally

important and would contribute significantly to increasing attendant confidence and competence, and ensuring quality in service delivery.

CDS Employers: CDS employers need to receive information and hands-on opportunities to train new employees. This is especially important for young adults who are becoming their own CDS employer. Although they are their own guardian, a young person or new CDS employer may not have had an opportunity to interact as an employee or employer in the workplace. Extra training may be needed to enhance managerial skills, such as interviewing, hiring, training, supervising, and terminating employees.

Proposed Solution

Provide funds for:

- CDS employers and non-CDS LTSS providers of services to individuals with IDD and other disabilities to be able to offer attendants enhanced training, including the following habilitation, complex needs, documentation, and EVV requirements.
- CDS employers to have opportunities for enhancing managerial skills, as they relate to hiring, training, supervising and terminating.

Request / Recommended Course of Action

Request funds to support the ability of CDS employers and non-CDS providers to offer attendants enhanced training/ongoing skill development. The funds requested could be made available through a "program" similar to the current Attendant Compensation Rate Enhancement Program, via an add-on rate, or as a program service for which evidence must be demonstrated and verified that the funds were used in accordance with their intended purpose.

Request funds for CDS employers to develop and enhance managerial skills, such as interviewing, hiring, training, supervising, and ~~or~~ terminating employees.

Topic: Expanded Behavioral Health Resources

Overview / Background

There is a dearth of providers trained in serving the behavioral health needs of people with IDD. Even for people who have financial resources such as commercial

insurance or access to comprehensive services through a Medicaid program, it is difficult or impossible to access qualified practitioners. The challenge is even greater for people who are uninsured on interest lists waiting to access comprehensive services. People with IDD and behavioral health issues need access to qualified health care practitioners *and* specialized resources such as respite and resource centers, highly trained behavioral analysts, family education and supports, and in-home assistance. These resources should be strategically placed across the state to meet the needs of the diverse population. In addition, access should be expanded through the use of technology and telehealth.

Proposed Solution

Expand current programs and create new comprehensive programs. Programs, at a minimum, should include:

- Evaluation and assessment to identify medical, psychiatric, and environmental factors
- Coordination between the supports for the person including providers, family, specialized behavioral health supports
- Crisis respite services that allow for alternatives to hospitalizations and also allow for planned respite for evaluation purposes
- Training and consultation from highly trained clinical staff
- Training for IDD providers
- Training and consultation for behavioral health systems in the specialized needs of the IDD population
- Availability of follow-up services to maintain progress, and
- Development of cross-system crisis prevention and interventions to assure providers and families have options that limit the inappropriate use of police and emergency rooms for behavior interventions

Request / Recommended Course of Action

The development of comprehensive, evidence-based initiatives to meet the behavioral health needs of people with IDD, enhancing current programs where available and developing new programs when necessary. Program should be comprehensive in nature, and include both out-of-home options and in-home supports. Texas should support the development of a model program for meeting the behavioral health needs of people with IDD.

Implement a one-year presumptive level of need (LON) 6 or 9 for individuals enrolling from other institutional settings or aging out from Comprehensive Care Program (CCP) skilled nursing, not limited to state supported living centers (SSLCs) as is the current policy.

Topic: Housing Transition Specialist

Overview / Background

For individuals with IDD, there is a lack of affordable housing options and formal supports to help people find the best housing solution.

Proposed Solution

Create Housing Transition Specialist to assist people with intellectual and developmental disabilities to transition to the most appropriate housing for the individual. Provide funding for Housing Transition Specialists to assist consumers and families, case managers, service coordinators and low-income individuals with intellectual and developmental disabilities transition and provide housing related services.

Request / Recommended Course of Action

Request appropriation and legislative approval to fund a Medicaid waiver benefit for Housing Transition Specialists.

Topic: Enhanced Staffing and Supports to Address Complex Needs

Overview / Background

There are many longstanding challenges in the delivery of LTSS to individuals with IDD. Critical issues include basic and enhanced attendant qualifications, attendant pay, recruitment and retention, assurances for quality care and continuity in care, and nursing coordination and oversight.

Although not inclusive of all strategies to address the aforementioned issues, providers of LTSS for individuals with IDD need access to sufficient funds to achieve:

- enhanced staffing ratios,
- augmented training,
- increased qualifications and pay for direct support staff serving individuals with complex needs,
- professional support for direct support staff, and
- billable nursing coordination and oversight services to persons with high medical or behavioral challenges.

Provision of Enhanced Support: When staff do not feel supported or are not provided the tools and training necessary to execute their responsibilities, they are not satisfied with their job and may place the health and safety of individuals at risk. The provision of enhanced support (whether through additional direct support staff, on-site training, increased qualifications and compensation for direct support staff serving individuals with complex needs, nurse coordination and oversight and coaching by certain professionals, such as in settings in which individuals with high medical or behavioral challenges reside) would increase attendant confidence and competence, ensure the health and safety of individuals being served, and subsequently, reduce costly transitions to hospitals, emergency rooms or institutional settings.

Proposed Solution

Provide initial and ongoing funds for LTSS providers, including CDS, of services to individuals with IDD to achieve the following: enhanced staffing ratios; training and higher rates for direct support staff serving individual with complex needs; professional support for direct service worker supporting persons with high medical or behavioral challenges; and billable nurse oversight and coordination (such as proposed by the High Medical Needs Workgroup and previously drafted in HCS rules amendments).

Develop and implement enhanced services and add-on rates for more complex services, service coordination, and monitoring for individuals with complex needs enrolling in waivers from the interest lists as well as those transitioning from an institution to the community.

The Eligibility to exceed an individual waiver cost cap should consider three factors: “the most integrated setting”, health and safety, and availability of living arrangements in which the person’s health and safety can be protected at that time. This would be consistent with the Americans with Disabilities Act and the US Supreme Olmstead decision. [Note: The language of “other living arrangement” has been used to deny waiver services and recommend placement in an institution.]

Request / Recommended Course of Action

Request funds for providers, including CDS, to provide enhanced staffing ratios, on-site professional coaching and nurse coordination and oversight as needed. The funds may be requested through a program similar to the current Attendant Compensation Rate Enhancement program, through a new add-on rate, or through high medical needs services rate for all IDD programs using attendant care or nursing. The funding guidelines should require evidence to demonstrate and verify that the funds were used for their intended purpose.

Because providers have been reluctant or unwilling to take on the liability of serving certain individuals due to medical or behavior acuity (high needs), ensure that payment is both justified and sufficient and that providers that overtly or covertly delay or deny services to certain high needs individuals face enforcement actions.

Assess and address the need for enhanced high needs services regardless of one’s entry to the waiver.

Address barriers for individuals with high needs that result in difficulty accessing or maintaining home and community-based programs and services. Strategies may include:

- Sustain and expand behavior, medical, psychiatric health, and other recent efforts such as crisis respite and include focus on preventing crisis and supporting families and providers of individuals who are at risk of placement in more restrictive settings.
- Implement enhanced payments for high medical needs across IDD programs for the most medically involved individuals at risk of institutionalization or hospitalization.
- Develop a high medical level of need (similar to LON 9 for behavior supports in HCS) in CLASS, DBMD, HCS and TxHmL.
- Use the Nursing Facility RUG or its successor to supplement IDD ICAP assessments and to demonstrate the need for a LON 9 or HCS high medical needs services. This cost-effective expansion of high medical needs initiatives can prevent a more restrictive, more expensive setting at a higher level of care and costs.
- Modify LON 9 criteria to address the need for 1:1 staff beyond aggressive behavior supports and supervision to include any behavior that is life threatening or puts a person at risk of medical or physical harm and requires the same level of supervision and intervention based on the individual’s needs.

- Implement a one-year presumptive LON 6 or 9 for individuals enrolling from other institutional settings or aging out from CCP skilled nursing, not limited to SSLCs as is the current policy.
- Define as a high needs population people with mobility impairments, who need help with transfers, use a manual or electric wheelchairs, or use other mobility aids, and who have difficulty accessing home and community-based programs and services.
- Provide additional formal training on how to safely transfer people with mobility impairments and complex medical needs from one location to another without risking injury to the member or the attendant providers.
- Fully implement a program for medically fragile individuals in the 1115 Star Plus program.
- Update General Revenue HHSC Rider 25, Waiver Program Cost Limits, to include consideration of services "in the most integrated setting appropriate for the individual". [Note: The current assessment to allow an individual to exceed their Medicaid Waiver individual cost limit is solely based on health and safety needs.]

Topic: HCBS Settings Rules

Overview / Background

HCBS Settings Rule: Residential Remediation Plan for Texas (HCBS) State Transition Plan (STP)

Effective March 17, 2014, CMS issued a rule under which states must provide home and community-based long-term services and supports in a manner that meets new requirements by March 17, 2022. The rule requires states to ensure that all settings in which HCBS is provided comply with the federal requirements that individuals are integrated in and have full access to their communities, including engagement in community life, integrated work environments, and control of personal resources.

The rule also includes a number of requirements for increasing self-determination and person-centeredness in the planning for and delivery of HCBS. Each state that has HCBS is required to file a State Transition Plan (STP) with CMS. The Texas STP includes timeframes and milestones for state actions, including assessment of the state's current compliance and, at a high level, planned steps for remediation.

Settings that are considered by CMS to presumably have the qualities of an institution have the effect of isolating individuals. If a state considers a setting presumed institutional to be integrated in the community the State should, per CMS strong encouragement, make an in-person site visit to observe the individuals' life experience and to ensure that the setting supports the inclusion of individuals in the general community. The expectation for HCBS-funded services is that people in the setting participate in community activities beyond those that involve only people with disabilities. Requests for review of a setting presumed institutional, known as "heightened scrutiny," must be submitted to CMS for additional review and approval through their heightened scrutiny process.

Proposed Solution

Assessment results indicated that individuals receiving HCBS need more resources in order to maximize their participation in the community and comply with CMS requirements. HHSC proposes to achieve this in part by creating a new service focused on community participation: ISS. This proposal also outlines a new fee to support community participation and new options for non-medical transportation, as well as clarifying service and policy expectations of how existing services are delivered.

For purposes of this proposal, references to residential provider include HCS three- and four-person homes; HCS host home/companion care; and DBMD assisted living facilities and one- to three-person homes.

Service and Policy Clarifications

In addition to new or significantly modified service definitions, assessment results indicate a need to clarify expectations of how existing services are delivered. Some providers have already incorporated these items into regular practice; for others, the modified services may necessitate a change. These include:

- Residential staff scheduling
- Person-centered service delivery
- Choice of staff
- Privacy
- Standardized residential lease
- Choice of home
- Employment

Request / Recommended Course of Action

After receiving stakeholder input and submitting a final remediation plan to CMS as part of the STP, submit new funding requirements for approval in 87th Legislative Session in order to meet the CMS implementation timeline.

- Fund all aspects of assessment, remediation, onsite heightened scrutiny and ongoing monitoring needed to become fully compliant with the HCBS rule.

Topic: Access to IDD Waivers

Overview / Background

In order to prevent unnecessary institutionalization, individuals with need timely access to waivers for interest lists and Promoting Independence. In addition, Medicaid beneficiaries eligible for Community First Choice (CFC) need education and information to sustain their life in a community setting.

Timely access to IDD waivers is limited. Waiting lists are long and do not move at a reasonable pace. Diversion and transitions are needed to prevent unnecessary institutionalization, including expanding diversion for all Medicaid waivers that do not currently have a diversion option.

CFC outreach was limited to individuals with IDD on interest lists for IDD waivers and was conducted when CFC was initially implemented June 1, 2015. Outreach to Medicaid beneficiaries eligible for CFC and other Medicaid State Plan benefits can be useful tools in ensuring health and safety, promoting community participation and preventing institutionalization.

Proposed Solution

Fund Interest List reduction, promoting independence slots for diversion and transition, improvements to CFC outreach to individuals with IDD and other waiver access improvements as follows:

Interest Lists:

- Implement no Interest List for SSI recipients when expanding managed care to new LTSS populations.
- Fund all Interest Lists reduction at least by 10 percent per year of the biennium for HCS, TxHmL, and CLASS.
- Fully fund the DBMD Interest List.

Promoting Independence:

- Fully fund all Promoting Independence related transition and diversion waivers at levels initially requested for 2016-2017:
  - 400 HCS slots for residents of SSLCs;
  - 100 HCS slots for residents of large and medium ICF/IID transitioning to the community;
  - 236 HCS slots for Department of Family and Protective Services (DFPS) children aging out of foster care with intellectual disabilities and add aging out HCS slots for individuals with developmental disabilities/related conditions;
  - 400 HCS crisis slots for persons at imminent risk of institutionalization;
  - 120 HCS slots for the movement of individuals with IDD from Texas State Hospitals;
  - 40 HCS slots for DFPS children transitioning from general residence operations facilities;
  - 700 slots for individuals with IDD moving from nursing facilities (NFs);
  - 600 HCS slots for individuals with IDD diverted from nursing facility placement; and
  - 550 MDCP slots for children diverted from nursing facility placement.
- In addition to the above Promoting Independence request, provide funding for the following service slots:
  - 20 HCS slots to assist children in moving from nursing facilities.
  - 35 HCS slots for children living in DFPS licensed IDD General Residential Options.
    - An additional 25 HCS slots for transition of children in Residential Treatment Center (RTC) facilities who have resided in the RTC for more than 12 months and are ready for discharge.
  - 100 CLASS slots for people at imminent risk of institutionalization and transition from large and medium ICFs/IID and NFs.

- 100 DBMD slots for people at imminent risk of institutionalization and transition from large and medium ICFs/IID and NFs.
- 100 STAR+PLUS slots for adults without SSI at imminent risk of institutionalization.

Outreach and Education Improvements: Community First Choice and Other Services under the Medicaid State Plan:

- Develop and implement CFC outreach strategies in collaboration with IDD SRAC, including but not limited to expanding outreach to individuals on all IDD Medicaid waiver Interest lists, Medicaid beneficiaries potentially eligible for IDD services, adults transitioning from school, and individuals receiving Medicaid acute care benefits through managed care organizations.
- Provide Outreach and Education and hold programs accountable for ensuring those with Medicaid are comprehensively assessed to properly identify needs and are able to access needed services through the Medicaid State Plan while waiting for a waiver or when on a waiver program.

Other Waiver Access Improvements:

- Provide funding for the appropriate waiver when an individual is found to be ineligible for their current waiver (for instance: MDCP to HCS).
- Ensure program policies and funding (billing) to provide supports at the time of day they are needed, such as overnight staff in one's own home or family home and protective supervision.
- Provide oversight and training on preventing inappropriate gaps in Medicaid eligibility.
- Ensure individuals get the services that best meet their needs by creating a bridge between waivers when needs or eligibility changes.
- Create a Texas TEFRA program for children with medical or behavior complexity. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) is federal tax legislation passed in 1982 under the Reagan administration for children to help certain children with complex needs under 19 years of age access health care, maintain health and safety and prevent institutionalization by not counting family income.

Request / Recommended Course of Action

Submit waiver slot funding requirements for approval in 87th Legislative Session in order to reduce interest lists, fund Promoting Independence Medicaid waivers and improve CFC utilization provide access to children's Medicaid for individuals under 21 years of age through TEFRA and prevent inappropriate gaps in Medicaid eligibility.

Topic: Improving IDD Assessments

Overview / Background

Capacity for accurately assessing needs and assigning an appropriate level of need and resources is critical to individuals and providers so that individuals can live and receive high quality services in the most integrated setting.

IDD assessments must become more comprehensive and the payment level sufficient to achieve and maintain optimal health, quality of life, and community living.

Request / Recommended Course of Action

Note: These suggestions are for all IDD programs and, as appropriate, replication in other programs servicing additional disability and aging populations, not limited to IDD.

- Immediately change the grading/scoring of the ICAP so that an individual needing behavior supports is not required to have an existing behavior management plan in place.
- Expand the IDD Assessment Pilot to include additional InterRAI modules based on the individual's needs, including, but not limited to: intervenor supports, medical, behavioral, psychiatric and other needs. [Note: while the pilot focuses on individuals with IDD, the InterRAI is a tool purported to be useful across-disability and aging populations.
- Create due process rights so individuals and their representatives, not just providers, have the right to appeal a level of need determination. Ensure that UR recognizes the influx of individuals with more significant needs into waivers and that not everyone is a LON 5. LIDDAs, individuals, and families should have all relevant information related to a decision by Utilization Review not to accept the LIDDAs LON recommendation and the right to appeal to a higher authority.
- Provide, pay for group homes staffing for evening and weekend to increase community participation in residents' preferred activities.
- Develop retirement options lacking for individuals with IDD who choose to retire based on stakeholder input (with significant input from self-advocates age 50+), and ensure that CFC and IDD service direct care staff and service coordinators are fully trained on person-centered approaches to use in assessment and service planning with aging individuals they serve. This will help not only with identifying goals, preferences and needs of aging individuals with IDD, but also ensure that person-centered approaches result in desired outcomes for individuals of all ages receiving services.

Topic: Public Access to Timely Regulatory Findings, Complaints, Surveys and Investigations

Overview / Background

HHSC's online information related to long term supports and services surveys and deficiencies is very outdated and less detailed than in prior years, preventing individuals from making informed choices regarding provider selection. Additionally, backlogs regarding investigation of abuse, neglect and exploitation increase risk of harm to individuals and a hardship on providers to maintain continuity of service delivery. HHSC's website currently indicates that critical public information has not been updated since August 2018.

Proposed Solution

Providing the resources needed for the public and policymakers to easily see complaints, surveys and enforcement actions would result in increased health and safety for individuals and access to key information for local and statewide policymakers. Timely ANE investigations would improve quality of services for individuals and lessen the opportunity for gaps in services or unnecessary expenses for providers when the staff needs to be removed to protect individuals pending the outcome of an investigation.

Request / Recommended Course of Action

Increase transparency of and processes for investigatory and regulatory oversight of programs for individuals with IDD and other disabilities to promote informed choice of providers, timely investigations of complaints and improved quality of community services. On HHSC's website, provide timely updates and a more detailed description of compliance with standards, citations and enforcement actions in programs serving individuals with IDD and other disabilities. Provide timely investigations of possible abuse, neglect and exploitation. These initiatives will require additional resources.

Day Habilitation and Employment Services Subcommittee

Topic: Community Integration and Community Integration Supports

Overview

Community Integration (CI) and Community Integration Support (CIS) are critical components for state compliance with federal HCBS regulations. The state has recognized that current day habilitation settings are not compliant with HCBS Settings Rules, and the draft interim plan expects that reform to day habilitation settings and the development of additional services will take effect by 2022. In order to streamline efforts in a cost effective and efficient manner, Texas Health and Human Services Commission (HHSC) should simultaneously request funding for day habilitation changes (presumably to Individualized Skills and Socialization (ISS) services) and the new CI services. Most individuals with IDD in the CLASS waiver are receiving their attendant services in the home and have limited community integration. The new services of CI and CIS should be available in all waivers to ensure all participants have the benefit of community integration.

Rationale for Recommendation

Compliance with federal HCBS regulations, effective and efficient use of funds for compliance. Dual roll-out encourages movement of individuals to the least restrictive settings and provides the state the time necessary to develop and promote the new service.

Proposed Solution

Fund CI and CIS services for all waivers so that Texas can transition effectively and fully into compliance with the HCBS settings rule.

Recommended Course of Action

HHSC should request funding in all waivers for: Community Integration

- Community Integration Support
- Funding should include expected increases in transportation costs and activity fees

Topic: HCBS Settings Rules

Overview

Federal HCBS Settings Rules require states to ensure individuals receiving services are truly integrated in the community and have choice over their daily lives including their schedules. Texas must have a transition plan approved by 2019 and show full compliance by 2022.

HHSC has recognized that day habilitation services in the HCS, Texas Home Living (TxHmL) and DBMD waivers will require significant programmatic changes and funding to meet federal standards. Individuals in the CLASS waiver are also mostly receiving services in the home.

Rationale for Recommendation

Texas needs to significantly improve services for individuals with disabilities to fully comply with HCBS settings and ensure that individuals with disabilities have access to the general community.

Without appropriate funding, compliance will be limited and the number of day habilitation providers will dramatically decrease reducing choice and negatively impacting individuals in the program.

Proposed Solution

Fully implement a robust set of modifications to programs and services in order to comply with HCBS settings and person-centered planning and service rules and guidelines from the Centers for Medicare & Medicaid Services (CMS).

HHSC should fully and appropriately fund reforms to day habilitation services (or fully fund services under reformed program under their suggested name “Individualized Skills and Socialization” — or something less confusing due to many younger persons understanding of ISS as “in-school suspension”).

Recommended Course of Action

Provide adequate funding for an improved day habilitation service so it can transition into ISS service, as designed by this committee and HHSC. Funding should include additional transportation costs, additional staffing (reduced ratios), and additional supports for individuals with complex medical and behavioral needs.

Provide funding for CI and CIS in the CLASS waiver as well to ensure individuals with IDD are more integrated into their communities.

Topic: Day Habilitation Services

Overview

Ensure day habilitation services are monitored to provide appropriate quality services. Fully implement a robust set of modifications to programs and services in order to comply with the HCBS settings and person-centered planning and services rules and guidelines from CMS.

Rationale for Recommendation

Day habilitation programs in Texas currently are facility-based and not directly regulated or inspected for accessibility or physical environment. No standard requirements are in place so that day habilitation programs can improve services. Competition and transparency would drive day habilitation provider accountability improving the experience of individuals seeking day services.

Texas needs to significantly improve services to individuals with disabilities to fully comply with HCBS settings and ensure that individuals with disabilities have access to the general community.

Proposed Solution

HHSC should request funding to:

- Develop a registration process for day habilitation and pre-vocational programs funded with home and community-based dollars
- Set standard expectations for day habilitation and pre-vocational programs funded with home and community-based dollars
- Conduct regulatory site visits (at least annually)

Recommended Course of Action

With diverse stakeholder input, create day habilitation standards and adequate resources to provide incentives for activities that provide integration into the community.

Increase funding for day habilitation so they transition into fully integrated day services, including:

- ● Conducting annual onsite inspections (similar to residential reviews)
- ● Creating outcome-based measures that are tied to HCBS compliance and
- ● Adding day habilitation operations to the searchable QRS system, using a scoring system created with stakeholder input

Increase opportunities for quality, person-centered day and pre-vocational services to implement HCBS settings and person-centered approaches.

Topic: Competitive, Integrated Employment

Overview

Develop and/or expand individualized, person- and community-centered approaches to competitive, integrated employment to include competitive wages and integrated settings.

Rationale for Recommendation

Individuals with IDD, compared to individuals with other disabilities and individuals without disabilities, experience a higher rate of unemployment. Many of those with IDD who do work are often in segregated settings and are paid sub-minimum wages.

SB 1226, The Employment First Bill, addresses this need for competitive, integrated employment for all Texans with disabilities and it is yet to be implemented. The HCBS CMS settings rule also addresses this in regard to integrated services being required.

Service plan implementation lacks flexibility to support individual choices related to competitive, integrated employment and volunteer and community exploration related to community jobs, in part due to the lack of providers of employment assistance and supported employment and transportation limitations. There needs to be a "pool" of trained service providers in order for consumers to access the services of employment assistance and supported employment. Although these services are offered, there is a serious lack of providers of these services, therefore those who want to work are unable to do so.

Individuals with IDD who have higher support needs, such as behavioral supports, require staff who have a higher skill set, which would require a higher pay rate.

Many individuals with IDD and providers of services have no knowledge of how to access employment services through Texas Workforce Commission (TWC) or the waivers or how to develop and implement an employment plan including exploring local job opportunities, negotiating job responsibilities, and providing ongoing or occasional supported employment job coaching.

Proposed Solution

Implement the Employment First Bill (SB1226), which states that competitive, integrated employment is the priority and preferred outcome for people receiving public benefits, which would:

- Increase the number of individuals with IDD receiving employment assistance and supported employment services (vocational rehabilitation (VR), Medicaid waiver services of employment assistance and supported employment, state funded).
- Increase the percentage of waiver and other funds spent on competitive, integrated employment services relative to the percentage of dollars spent by all other day programs/services (documented as facility or community-

based) and segregated employment (such as sheltered employment or pre-vocational services).

- Add Career Planning as a Medicaid waiver service that would provide a person-centered, comprehensive employment planning and support service. This service would provide assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. Include transportation between the participant's place of residence and the site where career planning is delivered as a component part of career planning services. The cost of this transportation is included in the rate paid to providers of career planning services and the state would include a statement to that effect in the service definition.
- Provide funds to establish an HHSC Employment First division which will provide consumers with information and training in regard to competitive, integrated employment and will provide recruitment of employment services providers as it relates to competitive integrated employment. This Employment First Division would be a centralized source of resources for employment related services and supports.
- Increase flexibility of services and supports to better provide choice regarding competitively paid, integrated community employment (full or part time) that promote self- sufficiency and non-paid volunteer work that will lead to employment that allows meaningful contribution to the needs of one's community-based on an individual's interests and preferences.
- Provide funding for a network of trained employment specialists to be available to individuals in all the waivers to provide employment assistance and supported employment services.
- Provide an increased provider rate for those providing employment assistance and supported employment to those with a higher level of need and support such as for those with behavioral needs.
- Provide funding to promote awareness about how to obtain employment services and provide outreach and training to potential users and providers of employment services to include how to develop and implement an employment plan including exploring local job opportunities, negotiating job responsibilities, and providing ongoing or occasional supported employment job coaching.
- Provide the assistance needed for the day services providers to adhere to the Texas Employment First Policy.

Recommended Course of Action

- As part of the implementation of the Employment first legislation, SB1226, request funds to establish an HHSC Employment First division and staff dedicated to employment services which will provide individuals with IDD with information and training in regard to competitive, integrated employment and will provide recruitment of employment services providers as it relates to competitive integrated employment. This Employment First

Division would be a centralized source of resources for employment related services and supports.

- Request funds for Career Planning as a Medicaid waiver service that would provide a person-centered, comprehensive employment planning and support service. This service would provide assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Request these funds to include transportation between the participant's place of residence and the site where career planning is delivered as a component part of career planning services. The cost of this transportation to be included in the rate paid to providers of career planning services.
- Form a network of trained and qualified employment specialists to be available to individuals in all the waivers and request any funds if they are needed to do so.
- Request funds to establish a consistent rate structure across all waivers for employment assistance and supported employment that provides a higher reimbursement rate for individuals with higher support needs (such as behavioral supports).
- Request funds to promote awareness about how to obtain employment services and provide outreach and training to potential users and providers of employment services to include how to develop and implement an employment plan including exploring local job opportunities, negotiating job responsibilities, and providing ongoing or occasional supported employment job coaching.
- Request funds to create initiatives for employment assistance providers/counselors/specialists to be present in segregated work settings to establish ongoing relationships with the employees and assist them to transition to competitive, integrated employment.
- Request funds to provide day services providers with the training they need to comply with the Employment First policy to create a transition plan for all individuals participating in facility based segregated work environments that pay subminimum wages, to move to integrated day services and employment
- Request funds to incentivize day habilitation providers, community rehabilitation providers, and other interested programs/parties providing services in segregated work settings to reallocate resources to competitive, integrated employment.

Topic: Competitive, Integrated Employment

Overview

Collaborate and expand partnerships to promote understanding and use of Social Security Administration (SSA) work incentives, VR services and Medicaid waiver Employment Assistance and Supported Employment services.

Rationale for Recommendation

Despite the availability of SSA initiatives, work incentives and the Ticket to Work program, these employment services remain underutilized nationally and in Texas, particularly for individuals with intellectual and developmental disabilities.

Texas Medicaid waiver employment services of Employment Assistance and Supported Employment are grossly underutilized.

Proposed Solution

- Increase public awareness and provision of accurate information and assistance to individuals with IDD, families, legal representatives, supported decision makers, managed care companies, Local Intellectual and Developmental Disability Authorities (LIDDAs) and IDD providers regarding:
  - Plan for Achieving Self-Support
  - Impairment Related Work Expenses
  - Student Earned Income Exclusion
  - Ticket to Work
  - Employment services (employment assistance/supported employment) provided through Medicaid waivers
- Increase availability, accountability, and utilization of Medicaid waiver employment services.
- Provide SSA benefits counseling as a service in all waivers
- Establish an HHSC designated employment division and staff dedicated to employment services for individuals with IDD.

Recommended Course of Action

- Request funds to promote competitive, integrated employment by developing and/or expanding existing educational campaigns and other initiatives to not only increase awareness of work incentives and provide accurate information, but to also assist with applying for and implementing work incentives that allow individuals who receive SSI to exclude money, resources, and certain expenses from total earned income.
- Request funds, if needed, to provide a required Employment First and Employment Services training for all direct service agency providers of Employment Assistance and Supported employment and case managers, including how to collaborate with local businesses, training about VR services, such as Ticket to Work and other support services that can be accessed through any participating employment network or state VR services so that the providers can better assist individuals to pursue person-centered competitive, integrated employment goals.
- Request funds, in conjunction with TWC, to provide training to IDD Medicaid waiver providers, day habilitation providers and other interested parties on how to become successful employment services providers in order to have a "pool" of providers for employment assistance and supported employment services.
- Request funds to establish an HHSC Employment First division which will provide consumers with information and training in regard to competitive,

integrated employment and will provide recruitment of employment services providers as it relates to competitive integrated employment. This Employment First Division would be a centralized source of resources for employment related services and supports.

- Request funds to add the service of SSA benefits counseling to all waivers.
- Request funds for HHSC to expand and enhance local employer recruitment training efforts to increase the employer base for those with disabilities.

Topic: Pay Rates for Direct Care Staff

Overview

Currently, direct care staff who are expected to provide supports that are more specialized or require additional skills (for instance, employment assistance and supported employment for individuals with higher support needs) are not compensated for their expertise, making it difficult to hire and retain qualified staff.

Rationale for Recommendation

In order to attract and retain the best possible staff, there needs to be sufficient pay that matches the skills of the staff. Successful staff in this field require extensive training and experience. There needs to be incentives put in place to achieve desired goals and maintain best possible results for the individual.

Proposed Solution

Pay an increased rate for staff who need a higher skill set based on the individual's level of need (such as behavioral supports, multiple disabilities, etc.) and create a career ladder for direct care staff. The compensation rate should be comparable with others in these fields in the area.

Recommended Course of Action

Establish a consistent rate structure across all waivers that provides a higher reimbursement rate for individuals with higher support needs.

Topic: Transportation Services

Overview

Add funding to allow more flexibility for non-medical transportation in all waivers (possibly for CI, CIS, ISS services and for employment purposes) such as buses, taxis, ride shares, etc.

Rationale for Recommendation

Transportation services need additional funding and flexibility so that individuals can use shuttles, vanpool/or minimum bus, taxis, ride share (Uber, Lyft, etc.). Individuals need the ability to get to and from ISS, employment, and CI services regardless of time of day, where the individuals live, or day of the week.

Proposed Solution

Increase funds and allow flexibility of use of funds so that individuals can access transportation that fits their needs

Recommended Course of Action

Provide flexibility in transportation services and increase funding as needed so that individuals can use transportation funds for taxi's, bus passes, ride shares, etc. This will allow individuals to access the greater community as individuals without disabilities do (regardless of time of day, weekday or weekend, rural or urban area)

Appendix C. IDD System Redesign Advisory Committee Recommendations

Transition to Managed Care Subcommittee

Simplify Accessing Dental Services

Background

Each program that provides services to persons with IDD under Texas Medicaid has unique and different requirements for accessing dental through the Medicaid waiver for adults with IDD.

Table 1. Requirements for Accessing Dental Services by Waiver or Program

Waiver or ICF/IID Program	Benefit Limit	Unique Rules
HCS	$2000	Specific dental limit. Built into initial and renewal plan of care based on need.
TxHmL	$1000	Specific dental limit. Built into initial and renewal plan of care based on need.
CLASS	$10,000	Combined with adaptive aids. Approvals required and not built into initial or renewal plan of care.
DBMD	$2500	Combined with adaptive aids. Approvals required and not built into initial or renewal plan of care.
ICF/IID	Traditional Medicaid[41]	Discussed at the annual staffing and recommendations for 3 months, 6 months or annual dental care based on need. There are follow-up meetings and appointments based on what was recommended in the staffing.
STAR+PLUS	$5000	Specific dental limit. Built into initial and renewal plan of care.

As reflected above, current HHSC rules apply different requirements to the IDD waivers and ICF/IIDs related to accessing dental services. With the addition of anesthesia for some dental procedures now being covered under Medicaid managed care, coordinating and accessing dental services has become more complicated, thus needing clarification and clear guidance from HHSC. This includes explaining

[41] See July 7, 2014, Information Letter 14-37 Re: Exceptions to Managed Care Expansion: https://www.dads.state.tx.us/providers/communications/2014/letters/IL201

how a dental value-added benefit impacts limits and processes in each of the programs. To streamline the requirements and to allow easy access to dental services for this population, the SRAC has the following recommendations.

Recommendations

1. For each HCBS waiver, include in the person's yearly plan of care the amount of services needed for dental for the year.
2. For CLASS, if the amount exceeds $2,000, the request for services will be reviewed by HHSC Utilization Review (UR).
3. As part of the development of the plan of care, HHSC will not ask for information on how much primary insurance will pay prior to services being rendered. However, once the claim has occurred, the dentist will include the amount paid by primary dental to assure there is no overpaid amount from Medicaid.
4. If using an anesthesiologist, the anesthesiologist and/or the facility will be paid by acute Medicaid or Medicaid managed care. The health plan must allow for an out of network (OON) anesthesiologist and facility to allow access to dental services. Clear guidance including coding for services is needed to describe facilities allowed to bill including the dental office, outpatient facilities, and inpatient facilities. Clear guidance is also needed when the dentist as part of the dentist's license applies anesthesiology services.
5. For any prior authorizations needed for dental services reviewed by HHSC, HHSC will provide a response within three business days of receipt of the treatment plan.
6. If the dental procedure exceeds the approved amount in the initial budget for the individual, the excess amount will be reviewed and approved if determined medically necessary without requiring the individual receiving the services to return for another procedure under anesthesia.
7. For TxHmL and HCS, HHSC should expand the approved list of covered Adaptive Aids to include dentures and implants with prior approval from HHSC.
8. Some services deemed as cosmetic should be reviewed to determine medical necessity, such as chipped teeth in a person who bites, has feeding challenges or other complications related to the needed cosmetic procedures.
9. HHSC should align policies across HCBS programs to allow for ease in access to services.
10. HHSC and the IDD SRAC shall work to build access to services for this population by working with dental schools across Texas.
11. HHSC and IDD SRAC shall develop methods to address accessing services through sedation early for a child through such strategies as Practice without Pressure to save Medicaid future dollars and result in better outcomes for the member.

Education on Transportation Benefits

Background

HHSC has made changes to the nonemergency medical transportation benefit for persons with disabilities. There is very little information on how to access nonemergency medical transportation for persons on Medicaid. The SRAC received several inquiries from persons with disabilities on how to access nonemergency

medical transportation, changes to the guidelines on nonemergency medical transportation and how to receive reimbursement when nonemergency medical transportation is provided through a private car.

HHSC set up regional managed care contracts with medical transportation providers to provide services to persons in Medicaid. As a result of this change further guidance for the program information was needed to ensure persons with disabilities can still access the nonemergency medical transportation benefit. Therefore, the IDD SRAC recommended the following.

Recommendations

1. Provide a clear understandable brochure to persons with IDD on how to access nonemergency medical transportation.
2. Distribute the brochure to the public through websites, sharing with organizations to distribute to their members and through mailings. In addition, provide brochure at annual service planning meetings and contacts with service coordinators and case managers (completed, awaiting distribution).
3. In the brochure:
   a. Provide information on who to contact and their contact information;
   b. Inform persons with disabilities on how to set up a ride;
   c. Provide information on how to be reimbursed when using a personal car; and
   d. Answer FAQs identified by the committee.

Monitor Quality on Acute and LTSS Benefits

Background

At this time, HHSC is not able to review and analyze quality metrics specific to the total population of individuals with IDD in the STAR Health, STAR Kids and STAR+PLUS programs. We strongly recommend HHSC and the MCOs work together to create a flag within relevant data systems to allow for tracking of quality and other metrics specific to individuals with IDD.

People with IDD are supported through a variety of managed care and non-managed care programs. Without a code, risk group, or other flag identifying an individual as a person with IDD in the data systems, data for individuals with IDD cannot be disaggregated from totals. At this time, individuals with IDD are unable to be disaggregated from total populations within STAR Health, STAR Kids, and STAR+PLUS acute care services and from STAR+PLUS HCBS LTSS services. HHSC, in collaboration with the MCOs, is able to pull metrics specific to a single sub-set of individuals with IDD, those who are currently supported through an IDD waiver. The other populations of people with IDD supported in managed care, including those not currently supported on an IDD waiver and those currently receiving STAR+PLUS HCBS Waiver services are not flagged.

General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017, Article II, Health and Human Services Commission, Rider 51 (formerly Rider 194) directs HHSC to develop community integration measures for STAR+PLUS and STAR Kids programs.

At present, this rider specifically applies to STAR+PLUS Home and Community-based Services (HCBS) and to the STAR Kids Medically Dependent Children Program (MDCP).

It is anticipated that the scope of this project will likely expand if more programs, such as IDD Medicaid waivers and Intermediate Care Facilities for individuals with IDD, are carved into managed care.

The Rider 51 – Community Integration Measures project is designed to gather data to assess the STAR+PLUS HCBS and STAR Kids MDCP program compliance with federal HCBS rules concerning community integration in areas such as: community participation, community presence, well- being, and recovery. HHSC is working with stakeholders to identify measures and establish methods of data collection. With stakeholder agreement, HHSC will collect data for measure reporting and publish final data on these measure on the HHSC website annually.

This process is currently conceptualized in two phases:

- Phase I will utilize currently available data streams and data elements from data sources available to the state as of January 2019.
- Phase II will expand upon Phase I measures to include measures derived from data elements that will become available after January 2019.

These phases are somewhat distinct and yet the analysis is being conducted somewhat in tandem, to the extent that is possible.

Progress to Date

- The state put forth two sets of draft measures to stakeholders based on currently available data. Stakeholders have not been satisfied with these measures and recommend the state utilize results of National Core Indicators surveys.
- The state believes the use of the National Core Indicator surveys to be within scope and is continuing to research this possibility.
- A new set of measures went out to stakeholders for review in mid-May 2019, to be followed up by a face-to-face meeting in July. Stakeholders were pleased to see that the new set of measures included National Core Indicator survey results, but recommend further refinement. The draft measures rely on National Core Indicators – Aging and Disabilities (NCI-AD); stakeholders recommend the additional use of National Core Indicators-Adults with IDD.

Recommendations

1. Create a system that is data-informed by developing mechanisms for recurring data collection and review of acute and LTSS data, what is used, what is needed, gaps, and implement evaluation of the data. Data must include aggregate information such as:
   a. Review plans of care based on individual identified needs and desires.
   b. Compare what was on plan, provided or not provided and why and overall service utilization.
   c. Identify services provided by one or more than one or different providers, such as behavior supports, PT, OT, which may be provided by non-licensed individuals that reinforce therapy according to the plan of care.
2. Establish and publish a dashboard to track data elements on the HHSC website
   a. Implement recurring data collection, assessment, review, action plan, and public reporting of results and expenditures related to publicly

funded services in coordination with the IDD Strategic Plan development and implementation.
   b. Ensure that state leaders have accurate, reliable data to use in development of policy and critical decisions that impact people with IDD.
3. Establish IDD population tracking codes within managed care.
4. Continue to seek and monitor IDD data on acute care, targeted case management/service coordination and LTSS quality measures using encounter data from Medicaid managed care organizations and other entities providing targeted case management/service coordination and LTSS using state data and National Core Indicators to obtain participant experience. In addition to NCI–AD, measures should include sufficient NCI IDD measures.
5. Evaluate and consider OPTUM recommendations for measurements and Utilization Management Review team information/data.
6. Ensure the committee will receive and review the results quarterly with HHSC to determine if the data are valid and can be used as baseline data for the future. The committee will continue to work with HHSC to refine the measures; and determine targeted case management/service coordination and LTSS measures that should be added and used to identify and address opportunities for improvement assessment and evaluation processes for people with IDD. The system should:
   a. Determine people's satisfaction and the flexibility of the system to meet their changing needs;
   b. Increase frequency of reviews throughout the year to ensure progress toward desired outcomes and preferences of the people using services and flexibility to make changes as needed;
   c. Increase number of people who choose or help decide their daily schedule;
   d. Increase number of people who use self-directed supports and participate in how to use supports budget, hiring, and services;
   e. Increase number of people and families who report high quality services;
   f. Increase number of people and families who report a high quality of life; and
   g. Decrease the number of people experiencing transitions to higher levels of care due to unmet needs (e.g., ER, hospitals, jails, NF, SSLCs and other institutions).

Identify and Develop Health Initiatives

Background

Identify and develop health initiatives that address acute care health needs common to individuals with IDD. Individuals with IDD, as a group, are living longer and need the opportunity to age well; however, certain health conditions are common to individuals with IDD and could be reduced or managed if initiatives are developed to build capacity to maintain optimal health and avoid ER, hospital and institutional long-term services and supports.

According to a November 2017 Policy Data Brief Titled Health and Healthcare Access among Adults with Autism Spectrum Disorder (ASD) and Intellectual Disability (ID) by the Lurie Institute for Disability Policy, adults with ASD and IF reported poorer general health than the general adult population of the United States. About 29 percent or 2,390 surveyed using National Core Indicators (NCI) with individuals who receive state developmental disability services reported at least one chronic health

condition such as diabetes, hypertension or high cholesterol. More than half of the respondents to their survey reported at least one diagnosis of mental illness/psychiatric condition (anxiety disorders, mood disorders, schizophrenia, etc.). Among those, three out of five took medication to treat those conditions and 24 percent who reported taking medications have no diagnosis on file. Most had access to primary care doctors, annual health exams, dental care and vision care. However, access to different types of preventive health screenings were uneven. Among women ages 21 to 65, 70 percent had a mammogram within the past 2 years, while 18 percent never had one. Among adults (men and women) ages 50 and above, 27 percent had never received a colon cancer screening.[42]

Recommendations

1. Expand quality-based outcome and process measures to include health care concerns impacting individuals with IDD such as obesity (due to medications), recovery based mental health services for individuals with IDD and co-occurring mental illness, diabetes, respiratory disorders, early onset Alzheimer's/dementia, heart disease, health literacy for self-care and decision making.
2. Improve access to preventive health services and access to timely and accurate psychiatric diagnoses and appropriate treatments.
3. Prevent having to go outside Medicaid to get health care services covered by Medicaid and create a mechanism to collect data from outside Medicaid when the individual uses non-Medicaid health care due to lack of access or as the primary insurer.
4. Ensure that SB 1207 regarding coordination of benefits, which was passed in the 2019 Legislative session, is implemented as written to allow Medicaid members to access Medicaid benefits for in network and out of network provider for copays, coinsurance and deductibles. Ensure Medicaid members are informed or educated about the revised coordination of benefits policy.
5. When Medicaid is the secondary insurer, ensure that Medicaid covers what the primary insurance does not cover, such as co-pays. Implement education and outreach to ensure Medicaid beneficiaries are aware to changes to be implemented due to recent legislation, including people on the Health Insurance Premium Payment (HIPP) Program who need coordination of benefits.
6. Encourage additional enrollments of health care systems and providers into Medicaid and Medicaid managed care.
7. To encourage health and wellness that may result in reduction of obesity rates, which are not always due to low physical activity levels, develop and implement easily understandable, targeted health promotion policies and practices that focus on nutrition, healthy lifestyle and diet.
8. Analyze data and, if needed, expand data collection to include access, availability, experience, utilization, and the results of health care activities (outcomes) and patient perception of care including use of NCI health and wellness data for individuals with ASD, ID and other developmental disabilities in order to identify health care initiatives.
9. Use MCO encounters and other HHSC data regarding hospitalizations and other physical and behavioral health related factors that lead to institutionalization in nursing facilities, ICF/IID, SSLCs, State Hospitals and other long-term care institutions information to identify and address health

[42] http://lurie.brandeis.edu/pdfs/policy-briefs/OlderYouthSSI2.pdf

initiatives to prevent admissions and facilitate returning to the community for individuals with IDD.

10. Track and report quarterly to SRAC the number and type and health related reasons for admissions, the number of discharges of individuals with IDD, including where they were admitted from, whether they had access to health care or community services by program, length of stay and where they were discharged to by program.

Develop and Implement a Regional Partnership

Background

Funding is needed to develop and implement a regional partnership throughout Texas for LIDDA, MCOs, providers and persons with IDD to better coordinate services and support for persons with IDD, to develop local solutions, strong collaborative partnerships resulting in better health outcomes for persons with IDD.

Persons with IDD may experience barriers to living successfully in the community, to include finding services, receiving coordinated care, understanding benefits, developing a plan for the future, and have opportunities to live and to work in the most integrated environment. The IDD SRAC recommends that Texas HHSC develop regional partnerships throughout the state of Texas. Again, the goal is to have better outcomes for persons with IDD.

Recommendations

1. Develop and implement a regional partnership throughout Texas for LIDDA, Medicaid MCOs, TEA, TWC, comprehensive providers and persons with IDD, and families to better coordinate services and supports for persons with IDD, to develop local solutions, and to develop strong partnerships resulting in better outcomes for persons with IDD.
2. Explore options for leadership roles to develop and operationalize regional partnerships.
3. Initiate regional partnerships prior to the STAR+PLUS Pilot Program in order to best support the goals of the pilot.
4. Increase coordination and collaboration between MCOs, local providers and state agencies (e.g. TEA, HHSC, DSHS, LIDDAs, TWC, and DFPS) to ensure appropriate and timely transition to adult services including competitive and integrated employment.
5. Pursue public-private partnerships to develop cross-system collaborations and innovative funding options to offer people with disabilities meaningful access to the same opportunities as their peers without disabilities.
6. Increase use of the regional education service centers' statewide networks to develop and provide innovative leadership development, training, and support for education for both professionals and families.
7. Increase regional and statewide resources and personnel to develop and implement inclusive competitive and integrated employment programs for students.

Improve the IDD Assessment Process

Background

At this time, much of the IDD service delivery system relies on an individual's assigned Level of Need (LON) to determine resource allocation for the individual, including staffing ratios in certain services. Many individuals with IDD in Texas are

assessed for their LON using the Inventory for Client and Agency Planning Resources (ICAP).

Like any tool, the ICAP has strengths and weaknesses. After years of experience with the ICAP, stakeholders identify strengths as its relative speed and ease of administration. The ICAP can be performed by non-clinical staff, allowing for Local IDD Authority case managers who are familiar with clients and experienced with person-centered planning to administer the tool. Weaknesses include the ICAP's focus on recent behavior to the exclusion of past history and traumatic events. The striations within the tool are limited to only four generally available LONs (five including the highest, LON 9, which is rarely assigned and not available for medical or physical needs). The four commonly assigned LONs are too broad to account for the tremendous variations in abilities and needs from person to person and to capture differences in a single individual's needs in different settings (e.g. an individual may have much higher needs when in a crowded, unpredictable community setting such as a shopping mall than in a familiar, controlled setting such as a day habilitation site).

In recognition of these and other challenges, Senate Bill 7 (2013) directed DADS/HHSC to develop and implement a comprehensive, functional assessment instrument for individuals with IDD to ensure each individual receives the type, intensity, and range of services appropriate and available. In April 2015, legacy DADS determined it would pilot the International Resident Assessment Instrument (interRAI) Intellectual Disability assessment.

Over the summer of 2017, HHSC used an outside vendor to conduct assessments using the InterRAI ID assessment on voluntary pilot participants. Participants were selected from among individuals receiving services through HCS, TxHmL, CLASS, DBMD, ICF-IIDs, and SSLCs. HHSC sought a sample of no fewer than 1,368 individuals aged 18 or older and drew from rural and urban areas, specifically Lakes Regional, MHMR Tarrant, Metrocare Services, and LifePath Systems' Local IDD Authority Service Areas, along with Denton and Mexia SSLCs.

Recognizing the anticipated timeline for completion of the InterRAI Pilot is 2022, with an indefinite period of time needed after completion of the pilot to develop a resource allocation algorithm if HHSC chooses to implement the InterRAI, the IDD SRAC strongly recommends HHSC work on dual tracks, to improve and modify use of the ICAP at present, while also preparing for the future where the InterRAI may be in place.

Recommendations

As the State moves forward with statutorily directed changes to the assessment, the IDD SRAC recommends improving assessment tool(s), processes and planning for needs:

1. Implement person-centered, individualized and comprehensive training and assessments;
    a. Support comprehensive and accurate assessment of functional, medical, psychiatric, behavioral, physical, and aging needs in all settings and that results in receiving appropriate services regardless of settings.
    b. Allow and encourage using a variety of evidence-based, empirically-valid tools as necessary to accurately identify needs.

2. Expand or enhance assessment tools and resource algorithms that account for high support needs and changes in conditions across the life continuum of the individual, whether physical, medical, or behavioral;
    a. Ensure high quality services that align resources with assessed needs and preferences (adjust rates that support quality)
3. Across programs and settings, develop and implement flexibility in service planning and resource allocation based on assessed needs, including for, but not limited to, individuals transitioning to community settings from institutional settings who may need higher levels of support during periods of transition.
4. Ensure continuity and integrity of services for transitions across programs, settings and changes in needs.
5. Acknowledgment of the important role an individual's natural supports can play and a willingness to Provide justified family support services, such as additional respite or in-home supports, at the level necessary to support an individual to remain at home.
6. Ensure individuals receive the amount, type and duration of services needed without requiring natural supports beyond those voluntarily provided.
7. Increase and improve training for assessment personnel to ensure assessments and staff appropriately address cultural, language, communication, learning differences, and needs of children and adults and their families.
8. Increase access to board certified behavior analysts to identify and provide timely and appropriate functional behavior assessments and behavior intervention plans.
9. Increase and enhance mental health screening to obtain baseline information and identify needs.
10. During any system redesign that implements new or modified assessments, ensure people maintain their services with no significant reductions.
11. Maintain continuity and level of care when an individual moves across service or geographic areas.

Additionally, the SRAC recommends HHSC take the following actions to address immediate issues with the current assessment process:

1. Modify ICAP scoring requirements to allow for assignment of LON 9 to individuals without a behavior management plan in place if other evidence justifies assignment of LON 9 for a period of 12 months.
2. Automatically assign at least an LON 6 for a period of at least 12 months to all individuals transitioning from institutional settings (already in place for individuals transitioning from SSLCs, but not in place for individuals transitioning from Nursing Facilities and other settings) and aging out from CCP skilled nursing.
3. Adjust the ICAP and other assessment tools to better account for high support needs, including physical, behavioral, and medical needs that enable the assignment of an appropriate LON, including LON 9 for medical and physical needs, not just behavioral.
4. Review adequacy and accuracy of current assessment processes for STAR+PLUS HCBS, CLASS and DBMD.
5. Streamline Determination of Intellectual Disability and ID/RC and Related Conditions processes and study how other states complete this determination, such as not requiring repeating the DID or ID/RC at the current frequency unless requested by the individual or LAR.

6. Allow telehealth and telemedicine and other technology, unless contraindicated and when agreed to by the individual and LAR, to prevent delays in enrollment, prior authorizations, reassessments and renewal of IPCs.

Day Habilitation and Employment Services Subcommittee

Identify Employment and/or Meaningful Day Goals

Background

There is currently no standardization in person-centered service planning across programs. Employment, and meaningful day activity goals are not consistently addressed in assessment tools across programs. In addition, the external assessment conducted by HHSC in compliance with the federal HCBS regulation indicated that exploring and obtaining employment is an interest of a significant number of individuals receiving HCS services and employment goals should be addressed to implement SB1226- the Employment First legislation of 2013.

Recommendations

1. Require a person-centered plan for all individuals that addresses competitive, integrated employment and other meaningful day activity goals.
    a. Include self-advocates in the discovery process by the development of a Peer Support Model benefit to assist individuals in identifying their meaningful day.
        i. People planning together- Learning Community
        ii. Opportunities for individual and group learning
        iii. Exploring how to support families and friends to understand the value and possibilities of employment.
    b. Review and develop recommendations to ensure that assessment and service planning questions are meaningful to individuals.
    c. The service planning discovery tool currently in development should include a specific module on employment.
2. Require that ALL Long-term Services and Supports (LTSS) providers including case managers, service coordinators, day habilitation providers and direct service agencies (DSAs) complete training in the principles of Employment First (EF), employment services, steps to become an Employment Services Provider (ESP) with Texas Workforce Commission (TWC), the development and implementation of an Employment Plan, work incentives and other resources to maintain benefits while working and the transition of services from TWC to LTSS/waivers.
    a. Improve electronic communication channels between TWC and LTSS providers and MCOs.
    b. Allow TWC to print application and eligibility determination letters for participants to be able to share with LTSS providers.
    c. Provide training that is affordable, accessible and available across Texas for all IDD LTSS providers and day habilitation providers to become successful Employment Services Providers (as the ESPs in TWC) in order to have a "pool" of providers for EA and SE services and to easily transition employment services from TWC to the waiver services.

d. Allow ESPs contract open enrollment to be available year-round.
e. Examine the current state contracts for training providers of EA and SE to reduce the overall time required for them to qualify as a credentialed provider.

3. For individuals desiring to seek or maintain employment, include TWC Employment Service Providers in the service planning to ensure participants have an Employment plan coordinated with TWC or other employment supports and include this plan in the participants individual plan of care in their waiver.
4. Promote awareness of employment supports through all means: case management, service coordination, person-centered planning, assessments, reviews, etc.
5. Require all TWC Vocational Rehab counselors to receive training from HHSC regarding Employment first principles, waiver employment program services and the process to transition employment services from TWC to long term services and supports/waivers.
6. Explore HHSC regulatory staff reviewing for compliance to Department of Labor standards for all sheltered based employment services paying less than minimum wages.
7. Explore additional strategies to increase competitive integrated employment as per the Texas Employment First policy including utilization of transitioning from the use of 14c waiver certificates.
8. Increase additional strategies that lead to skill development to increase competitive employment.

Increase Utilization of Employment Services

Background

Despite the passage of SB 1226 Employment First legislation of 2013 that establishes competitive, integrated employment as the primary goal and priority for citizens using publicly funded services, and the availability of Social Security Administrations (SSA) initiatives, work incentives and the Ticket to Work program, these employment services remain underutilized nationally and in Texas, particularly for individuals with IDD. In addition, Texas Medicaid waiver employment services of Employment Assistance and Supported Employment are grossly underutilized.

Collaboration and expanded partnerships are needed to promote understanding and use of SSA work Incentives, Vocational Rehabilitation services and Medicaid waiver Employment Assistance (EA) and Supported Employment (SE) services.

Recommendations

1. Require all LTSS providers to contract with a network of Employment Assistance (EA) and Supported Employment (SE) providers who meet quality standards to provide (SE) and (EA) services in order to meet the needs of the participants, including Employment Service Providers (ESPs.) The recommended Quality Standards include:
   a. The Employment Service Provider must have a discovery process in place that supports the individual to identify their employment capacities, abilities and preferences. Employment Assistance services used for discovery must reflect one-on-one interaction, business exploration and job training. EA service results in the person transitioning to Supported Employment Services.

   b. For all individuals receiving employment assistance services, individual employment plans must be reviewed by the service planning team every 6 months to discuss and remove any barriers to competitive, integrated employment.
   c. The Employment Service Provider must have a Supported Employment in place that includes employment placement, systematic instruction, fading of direct employment supports at the job site and long-term services.
   d. Supported Employment services matches the individual to a job that reflects their employment capacities, abilities and preferences to a full or part-time job in the community paying minimum wage or better.
2. Develop and facilitate regularly scheduled regional and/or local collaboration on employment issues, including state agencies that provide employment services [MCOs, Local Intellectual and Developmental Disability Authorities (LIDDAs), Direct Service Agencies (DSAs), TWC, Texas Education Agency (TEA) and Health and Human Services Commission (HHSC)] which will develop (1) a joint plan for identification of federal and state funding and resources to promote competitive integrated employment, (2) a joint phase-out plan that transitions individuals with disabilities out of subminimum wage and segregated work environments, (3) annual goals for increasing the numbers of persons with disabilities employed in competitive integrated employment and (4) a requirement for each agency to develop a system for collecting and aggregating data that follows Workforce Innovation and Opportunity Act (WIOA) requirements and is reported to the HHSC Employment First designated staff annually (this recommendation also requires TEA and TWC participation).
3. Require contractors and subcontractors to comply with Employment First policies by ensuring the primary goal is competitive integrated employment as outlined in the Government Code, 531.02447.
4. Expand the definition of Employment Assistance services to include providing a person-centered, comprehensive employment plan with support services needed. This could be similar to the Employment Plan used by TWC. This service would provide assistance for waiver program participants to obtain, or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. Include transportation between the participant's place of residence and the site where career planning is delivered as a component part of career planning services. The cost of this transportation is included in the rate paid to providers of career planning services and the state would include a statement to that effect in the service definition.
5. Establish a centralized source of resources for employment related services and supports including information regarding continued Medicaid eligibility.
6. HHSC to measure employment outcomes to support the implementation of Employment First initiatives.
7. Promote competitive, integrated employment by developing and expanding existing educational campaigns and other initiatives to increase awareness of work incentives and provide accurate employment information for pilot participants.
8. Add Social Security (SSA) benefits counseling as a service in all LTSS waivers to promote competitive, integrated employment by not only increasing awareness of work incentives and providing accurate information,

but by also assisting with, applying for and implementing work incentives that allow individuals who work to continue their Medicaid eligibility. The SSA benefits counseling will be provided by certified social security benefits counselors. This will ensure participants understand that their Medicaid waiver pilot benefits will be preserved after obtaining employment.
    a. Increase the number of certified social security benefits counselors by providing the necessary training in SS benefits. Currently there are less than 30 state certified benefits counselors in Texas.
9. Require and allow billing in the IDD waivers for EA providers to be present with an individual when a SE staff is being trained to ensure the transition from EA to SE is successful.
10. Establish a higher EA and SE reimbursement rate, in all waivers, for participants who have higher support needs, such as medical and/or behavioral supports, who require staff to have a higher skill set of training.
11. Establish a transportation benefit to allow flexibility to include the use of taxis, bus passes and ride shares and allow this to be billable through EA and SE services when it is employment related transportation.

Improve Community Access through Home and Community Based Services Regulations

Background

Currently, individuals with IDD receiving day habilitation services do not have full access to the greater community through their HCBS services. Service delivery design and reimbursement rates are barriers to individualized, integrated community participation, making person centered plans and implementation plans hard to fully implement.

Individuals, regardless of where they live, who receive day habilitation services get the services primarily in facility settings with no or limited access to the community during day habilitation services.

Recommendations

1. Pilot or phase in an hourly community integration service available to individuals regardless of their residential arrangement.
2. Develop and promote pooling of day services dollars to participate in shared interests in the community for up to three individuals to provide staff and transportation.
3. Provide funds to incentivize or reward creative service models that increase flexibility and support individualized, person- centered, lifespan goals to assist the state to come into compliance with HCBS requirements. (For instance: competitive/integrated employment, integrated retirement, community recreation, volunteering, or other activities identified as meaningful by the individual).
4. Incentivize waiver providers (DSAs-direct service providers) and day habilitation providers to become employment providers (such as ESPs in TWC).
5. Seek input from stakeholders in various settings with varying services to increase awareness of barriers to community inclusion.
6. Fully implement the Individualized Skills and Socialization (ISS) service proposed by the IDD SRAC supported workgroups to allow for choice of

meaningful day providers and day activities across settings in order to comply with the federal HCBS regulations.
7. Allow for flexibility of transportation services to support community participation activities.
8. Individuals in residential services should have increased flexibility and options for how they spend their daytime hours.

System Adequacy Subcommittee

Access to Services

Background

Timely access to IDD Medicaid-waivers and other waivers serving persons with IDD is limited and interest lists are extremely long, and in many cases, people wait more than fourteen years. As of March 31, 2020, the IDD Medicaid-waiver interest list included the following number of persons on the list: 76,856 for CLASS; 795 for DBMD; 106,567 for HCS; 88,533 for TxHmL; 11,342 for STAR+PLUS Waiver; and 6,081 for MDCP.[43]

It is Texas policy that children belong with families. The Texas Legislature funds waivers to support children and adults moving from facilities and divert them from facility admission as part of its commitment to Olmstead and the Texas Promoting Independence Plan. In 2019 the 86th Legislature funded new waivers slots for 1628 persons on the interest list. However, HHSC did not receive funding for Promoting Independence waiver slots for persons seeking diversion from admission to an institution or transition from institutions to the community during the 2020-21 biennium.

The Texas Legislature historical funding for HCS and TxHmL waiver services, interest list reduction for HCS, and HHSC appropriation & attrition for HCS waiver slot utilization for the 2020-21 biennium are outlined in the tables below.

An IDD Strategic Plan is under development and will provide additional perspective and recommendations to increase and improve access to community services, which will further enhance the service delivery system.

[43] https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction

Table 1. HCS Targeted Group Appropriated Slots by Biennium

HCS Targeted Group	Purpose	FY 2014-15	FY 2016-17	FY 2018-19	FY 2020-21
Crisis Diversion [44]	To prevent institutionalization/crisis	300	400	0	0
Nursing Facility Diversion [45]	For persons with IDD diverted from nursing facility admission	150	600	150	0
Nursing Facility Transition	For persons with IDD moving from nursing facilities	360	700	150	0
Child Protective Services Aging Out	For children aging out of foster care	192	216	110	0
Nursing Facility Transition for Children[46]	For children moving from nursing facilities	0	20	0	0
Large or medium ICF/IIDs	For persons moving out of an ICF/IID, including an SSLC	400	500	325	0
DFPS General Residential Operation (GROs)	For children moving out of a DFPS GRO	25	25	0	0
State Hospital (MDU)	For persons moving out of state hospitals	0	120	0	0
HCS Interest List Reduction	Statewide interest list reduction	1,324	2,134	0	1,320
TxHmL Interest List Reduction	Statewide interest list reduction	3,000[47]	0	0	0

[44] Crisis Diversion was known as SSLC Diversion in FY14-15 and FY16-17.

[45] FY14-15 HHSC (Prior to Transformation Department of Aging and Disability Services (DADS) used resource allocations to designate 150 slots for the purpose of diverting admission to nursing facilities.

[46] None specified in appropriations, but HHSC historically provides about 20 slots per biennium to help transition children from nursing facilities

[47] FY14-15 HHSC (Prior to Transformation DADS) used resource allocation to designate 125 slots for the purpose of diverting admission to nursing facilities via the TxHmL waiver

Table 2. CLASS, DBMD, MDCP & STAR+PLUS HCBS Appropriated Slots by Biennium

HCBS Program	Purpose	FY 2014-15	FY 2016-17	FY 2018-19	FY 2020-21
CLASS Interest List Reduction	Statewide interest list reduction	712	752	0	240
DBMD Interest List Reduction	Statewide interest list reduction	100	50	0	8
MDCP Interest List Reduction	Statewide interest list reduction	120	104	0	60
STAR+PLUS HCBS Interest List Reduction	Statewide interest list reduction	490	0	0	0

Table 3. HCS Attrition Slot Utilization for the 2020-2021 Biennium

Attrition Target Group	Purpose	FY 2020-21 Appropriated Slots	FY 2020-21 Total Released[48]	FY 2020-21 Total Enrollment	FY 2020-21 Total Pending
Crisis Diversion	To prevent institutionalization/crisis	0	357	221	127
Nursing Facility Diversion	For persons with IDD diverted from nursing facility admission	0	120	74	39
Nursing Facility Transition	For persons with IDD moving from nursing facilities	0	167	62	72
Child Protective Services Aging Out	For children aging out of foster care	0	91	56	34
Nursing Facility Transition for Children	For children (age 21 or younger) moving from nursing facilities	0	7	2	5
Large or Medium ICFs-IID	For persons moving out of an ICF-IID, including State Supported Living Centers (SSLC).	0	57	37	19
Totals		**0**	**799**	**452**	**296**

[48] Attrition slots require input from HHSC Budget to determine if resources are available and to what capacity for the specified point in time.

Table 4. HCS Interest List Reduction by Biennium

HCS Interest List - Biennium	Appropriated Slots	Total Released	Total Enrolled
2014-2015	1154	5885	3698
2016-2017[49]	2134	1793	1079
2018-2019[50]	0	0	0
2020-2021	1320	1529	459

[49] During fiscal year 2014-2015, HCS slots were overfilled in response to feedback DADS received about not filling slots quickly enough. The impacts of over-releasing names from the interest list resulted in exceeding the end-of the year target and impacted the total enrolled for fiscal year 2016-2017. *Waiver Enrollment Report (March 2017).*

[50] HHSC did not receive appropriations for HCS interest list reduction during fiscal year 2018-2019.

Recommendations

1. Fully fund 10 percent interest list reduction per year. The committee recognizes this does not fully address reasonable promptness or timely access to Medicaid services.
2. Fully fund sufficient Promoting Independence related transition and diversion waivers for children and adults, ensuring that the Texas Promoting Independence plan is comprehensive, effective, and timely in meeting demands. Ensure inclusion of initiatives benefiting children, including waivers to support children being diverted or moved from nursing homes and other institutional settings to community settings.
3. Provide outreach and training on how to access waivers, including the various attrition waiver slots, to the IDD population (persons and families) and those implementing the processes for accessing attrition slots. As LTSS services are carved into managed care over the next decade eliminate the LTSS interest list for SSI recipients who qualify for IDD waiver program. Consider HCBS waivers under Section 1915(c), 1915(k), or 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n(c) in addition to 1115 waivers which may be used to provide HCBS services to people with IDD who meet eligibility criteria.
4. Implement no interest list policy for eligible MDCP SSI recipients in STAR Kids and STAR Health managed care programs.
5. Continue the “bridge to the appropriate waiver” policy. When a person comes to the top of the interest list and is found to be ineligible based on disability or medical necessity, the person’s name is moved to the appropriate waiver(s) interest list consistent with their disability or medical necessity criteria at the original date that the person got on the waiver interest list for which they have been determined ineligible. MCOs, LIDDAs, service coordinators and case managers should inform persons of the policy and assist with the process to get onto the appropriate interest list(s).
6. Monitor modifications and the impact on persons waiting for services due to Rider 42 Interest List study, and while continuing to provide robust funding for waiver slots for Promoting Independence and Interest Lists.
7. Include and update as necessary IDD SRAC recommendations that help prevent unnecessary institutionalization and support timely access to services in the most integrated setting into the Texas Promoting Independence Plan.

Strengthen Support for People with More Complex Needs, Including Behavior Supports

Background

Enhanced services, coordination, and monitoring are not available to persons with complex needs across all IDD waivers. Behavior support professionals are in short supply, causing delayed assessment and services, which can lead to more restrictive, out of home placements. In addition, providers have been reluctant or unwilling to take on the liability of serving a person due to medical, physical, or behavior acuity (high needs).

Recommendations

1. Address barriers for persons with high needs that result in difficulty accessing or maintaining stability in home and community-based programs and services. For example, ensure that provider payments are both justified and sufficient and

that billing is allowed for critical services such as nursing, including supervision of non-licensed staff.

2. Establish clear expectations and ensure compliance for providers who delay or deny services to persons with complex or high needs by providing technical assistance and resources for successful services, and by tracking delays and denials.
3. Continue to expand the behavioral, medical, and psychiatric regional teams to serve all waiver programs and support Local IDD Authorities delivering evidence-based programs to provide training, technical assistance, and ongoing support for other Local IDD Authorities to expand use of evidence-based programs.
4. For new HCS waiver enrollments, accept the initial proposed Level of Need (LON) from the Local Intellectual and Developmental Disability Authority (LIDDA) for the first 12 months unless the LON is appealed due to not sufficiently reflecting the persons' higher LON.
5. Enhance capacity of crisis respite and long-term stabilization across all
6. waiver programs and in non-waiver services for all persons with IDD.
7. Ensure access to protective supervision /personal assistance services across all waiver programs.
8. Expand due process rights to appeal an LON determination, currently afforded to providers only, to persons and their representatives.
   Implement a one-year presumption of LON 6 or LON 9 for persons
9. enrolling from all institutional settings or aging out from CCP skilled nursing, not limited to SSLC transitions, and maintain, at a minimum, the LON of a person transitioning from another waiver or other IDD program for one year.
10. Improve and streamline the SSLC transition process and create successful and timely continuity of necessary supports and services.
11. Modify LON 9 to address the need for 1:1 staff beyond aggressive behavior supports and supervision to include any behavior, or medical or physical need, that is life threatening or puts a person at risk of physical harm and requires the same high level of supervision and intervention.
12. Create high needs services that support advanced direct service professional training, supervision and compensation when supporting persons with high medical, behavioral, physical or psychiatric needs.
13. Create an-add on level or "bump" in Community First Choice services and payment for persons with more complex needs.
14. Add higher level of services with higher total cost allowance for persons with the most complex needs in Medicaid, including in managed care and the IDD Pilot Program.
15. Streamline access to General Revenue funds for those who exceed the cost cap for person waivers, including in managed care and the IDD Pilot Program.

Create Housing Transition Specialist

Background

There is a lack of affordable housing options and no assistance for persons with IDD to help them find the best housing solution. Assistance to find appropriate housing can be funded as a Medicaid waiver benefit. Funding is needed for Housing Transition Specialist to assist consumers and families, case managers, service coordinators and low-income persons with IDD transition and provide housing related services.

The Housing Transition Specialist will educate a potential housing applicant on community living options, property availability, and the application process. The Housing Transition Specialist assists prospective applicant to apply for housing. The Housing Transition Specialist maintains relationship with landlords and property managers, will assist with application process and monitoring of application process ensuring all documents are submitted to prospective landlord. The Housing Transition Specialist works as a member of person centered practices team to communicate changes in housing application progression and to ensure awareness and coordination necessary for supports and services, and will assist with creative problem solving to resolve landlord/tenant issues, referral to other community resources as need is identified. The Housing Transition Specialist helps prospective and placed applicants to understand lease and tenant responsibilities, training on how to be a good neighbor, and to ensure the tenant understands how and when to communicate with a landlord. The Housing Transition Specialist works with other community housing services and resources such as Texas Department of Housing and Community Affairs (TDHCA) and the Project 811 Rental Assistance (PRA 811) program, Centers for Independent Living, Aging and Disability Resource Center (ADRC) Housing Specialist, apartment locator services, and other community, private, or state funded housing resources to identify safe, affordable, accessible, and integrated community living properties/options.

Recommendations

1. Create Housing Transition Specialist to assist people with IDD transition to the most integrated, appropriate housing for the person.
2. Request appropriation and legislative approval to fund a Medicaid waiver benefit of Housing Transition Specialist and supports.
3. Address barriers for persons with high needs that result in difficulty accessing and maintaining housing.
4. Explore opportunities to establish funding for security deposits and basic furniture/household items for those without resources.

Navigation Across the Entire IDD Service System

Background

Persons with IDD in Texas migrate across multiple services and service delivery systems over the course of their lifetimes depending on their age, medical needs, availability of services, and changing support needs and preferences. There is insufficient data to best evaluate when and why these migrations occur. The SRAC recommends reviewing the broader IDD system, across community and institutional services, in order to anticipate, plan and implement a more flexible and sensible system of supports and services whether in managed care or fee-for-service. The February 2019 Foundational IDD Strategic Plan is a start to better understanding the needs, services, gaps in services and timely availability of services. It is also an opportunity to more strategically use data that has historically been fragmented and not part of a strategic, actionable plan. The continued development of an IDD Strategic Plan will provide additional perspectives and recommendations.

Recommendations

System reform must assist persons with IDD to live full, healthy and participatory lives in the community. Specifically, the system reform must address the needs of persons and families to navigate the IDD and Home and Community Based Services (HCBS) systems successfully. In addition, the system must be designed to support

and implement person-centered practices, consumer choice and consumer direction. Persons with IDD and families should receive the assistance they need to effectively support and advocate on behalf of themselves and other persons with disabilities. The system must be accessible, easily understood and transparent for persons, including information about rights and obligations as well as steps to access needed services.

The Health and Human Services Commission should identify and obtain data needed to fully evaluate migration/transition of persons with IDD across systems, including the reasons and number of transitions, and provide recommendations on the delivery of services to facilitate timely access to the services most appropriate to person needs. HHSC should coordinate and consult with the SRAC on the following strategies:

1. Providing comprehensive data at least quarterly to the SRAC and the public regarding the requests for waivers, and enrollments by slot type, and the, interest lists by waiver type. In addition, providing data on institutional census, admission and discharge of persons with IDD including State Supported Living Centers (SSLCs), Intermediate Care Facilities (ICFs), General Residential Operations (GROs) and Nursing Facilities (NFs).
2. Improving Interest List data and tracking across programs serving persons with IDD including STAR+PLUS, including the number of persons on the interest list who are receiving institutional services by institutional type and waiver interest list.
3. Providing choice of the most appropriate waiver when a person in an SSLC or other institutional setting is transitioning to the community and would qualify for the Deaf Blind Multiple Disabilities (DBMD) or Home and Community Based Services (HCS) waiver.
4. Participating in the continued development of the IDD Strategic Plan and encouraging broad stakeholder input.
5. Continue contributing to the development, implementation and recommendations of the STAR+PLUS IDD Pilot for persons with IDD and similar functional needs and the Pilot Workgroup.
6. Implementing a well-coordinated transition and referral process when persons experience a transition in care. The transition processes should identify problems and explore options through local, state and Medicaid resources. Transitions in care may include changes in caregivers, MCOs, provider agencies or care settings.
7. Fully assessing a person with IDD at the time the person applies for assistance to determine all appropriate services for the person under the Medicaid medical assistance program, including both waiver and non-waiver services.
8. Ensuring procedures are operationalized for obtaining authorization for IDD Medicaid waiver services and other non-waiver services under the Medicaid medical assistance program, including procedures for appealing denials of service that take into account physical, intellectual, behavioral and sensory barriers and providing feedback on development of the new Independent Review Organization, including outreach and education.
9. Continuing use of HCBS waivers and other alternative programs to meet the support and service needs of persons on Interest Lists for IDD comprehensive waivers.
10. Consider waivers under Section 1915 (c), 1915(k) or 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n(c) in addition to 1115 waivers which may be used to provide HCBS services to people with IDD who meet eligibility criteria.

11. Ensuring compliance with policies that ensure that a child or youth receiving Medicaid services has access to the most appropriate, comprehensive waiver service as adults, based on that persons needs and preferences, when the person ages out of and loses eligibility for Medicaid State Plan or Medicaid waiver services for children. In addition, processes should ensure that families have access to education and resource information to successfully support their family member transitioning to adult services.
12. Establishing the family support necessary to maintain a person's living arrangement with a family for children and, if desired, for adults with ID.
13. Ensuring that eligibility requirements, assessments for service needs, and other components of service delivery are comprehensive, accurate, and designed to be fair and equitable for all families, including families with parents who work outside the home, parents who volunteer and parents who are not employed.
14. Providing for a broad array of integrated community service options and a reasonable choice of service providers, consistent with home and community-based service settings requirements, including improving use and flexibility of consumer directed services options and training for self-advocates to direct their own services when desired.
15. Evaluating the quality and effectiveness of services for persons with IDD, including persons with high support needs. The evaluation should address whether access to crisis services prevented or could have prevented the need to migrate to a more restrictive setting or a different Medicaid waiver.
16. Coordinating, or combining, statutorily required IDD-specific reports to allow for a broad view of the systems' strengths and weaknesses and a more accurate assessment of barriers and gaps to services. Note: There are numerous IDD-specific reports that identify barriers to community, including reports on referrals, provider capacity, affordable community housing, and other services and supports needed to ensure community stability. The data from these various reports needs to be coordinated in a focused assessment of barriers and gaps to services.
17. Monitoring the implementation and impact of managed care, new policies and initiatives required by the 86th Texas Legislature.
18. Identifying state agency staff to assist persons to understand, maintain, and manage their Medicaid benefits.

Increase Community First Choice Utilization and Improve Coordination

Background

As an early step in the IDD System Redesign, on June 1, 2015, Texas became one of the first states in the nation to implement Community First Choice (CFC). CFC was implemented as a Medicaid State Plan benefit, available for children and adults with Medicaid who meet an institutional level of care and have a functional need for services. The main services available in the CFC service array are personal assistance services (PAS), which involves assistance with activities of daily living (ADLs), such as bathing, dressing, and eating, and health related tasks; instrumental activities of daily living (IADL), such as money management, meal planning and preparation, cleaning, cooking, and shopping; and habilitation (HAB), which involves assisting a person to learn, develop and maintain skills for everyday life activities.

CFC in Texas was designed and implemented as a cost-effective alternative to institutional care. CFC's limited service array was meant to provide services and supports for thousands of Medicaid-eligible children and adults, many of whom are on IDD Interest Lists awaiting a more comprehensive package of services. CFC services could prove enough to meet the needs of some persons on interest lists, thus improving the person's quality of life and maintaining the person in the community, relieving family pressure, and possibly even eliminating the need for a person to remain on the interest list. For persons with more intense needs, CFC could provide a lifeline, keeping the person out of institutional care, while the person awaited a more robust service.

Unfortunately, the full promise of CFC has not been realized. The uptake rate for CFC (the number of people offered the service who accept) has remained lower than anticipated (according to "CFC Closures FY17" report, presented by HHSC to System Adequacy subcommittee at June 26, 2018 meeting). Stakeholders, including LIDDAs, who serve as the front door to CFC services for persons with IDD, and MCOs, who are responsible for overseeing the delivery of CFC services for many populations, report challenges related to outreach, coordination and data collection. Notably, LIDDAs found through their outreach efforts that many people offered CFC were not interested because the services offered did not meet the person's needs. Persons and families noted that the in-home assistance and habilitation available through CFC would be more beneficial when coupled with transportation and respite. Additionally, MCOs and LIDDAs both report problems with the reporting program between MCOs and LIDDAs where progress with assessments, timeframes, and outcomes should be captured.

The 84th Texas Legislature (2015) responded to the low uptake rate and stakeholders' call for a package of services more responsive to the needs of persons with IDD by appropriating approximately $30 million to add respite and transportation services to the CFC service array. Due to complications, these funds were never utilized for their intended purpose and the CFC service array remains unchanged.

Stakeholders note other significant difficulties with CFC implementation. Some additional factors include:

1. A lack of CFC direct service providers due to Medicaid reimbursement rates that do not cover the cost of service delivery. LIDDAs report that persons struggle to find a provider willing to provide services at current rates, even when providers in the area are contracted with MCOs to do so. State or MCO action to address network inadequacy is thwarted by a lack of statewide CFC utilization data.
2. HHSC has had issues running reports to examine data related to the number of persons who have been authorized for CFC services compared to the number of persons who actually received a CFC service.
3. Workforce, funding, and process challenges to timely assessments.
4. True education on how to provide habilitation to persons with IDD. More emphasis should be given to provide education to attendants doing the day to day work with members, so they are successful in helping members learn skills.

At this time, CFC remains a service with great promise and the state should invest the effort and resources necessary to increase utilization and improve coordination.

Recommendations

1. Increase awareness of CFC through a concerted, statewide outreach effort. HHSC should create a brochure and website content that describes CFC in a meaningful and, accessible way, to include eligibility requirements for the benefit and information on who to contact to request services. Distribution of education material should be provided to all persons served, providers and advocates of persons with IDD and MCOs. MCOs and LIDDAs should be required to discuss CFC services at annual assessments to ensure persons with IDD are aware of CFC and are routinely screened for eligibility and interest in the benefit. Ensure schools provide information to students with disabilities who may qualify for CFC services.
2. Enhance the CFC service array by adding transportation and respite services to the benefit.
3. Set sustainable CFC rates that allow for hiring and retention of direct service workers with skills and abilities in teaching habilitation. Rates for CFC services across all programs, including rates paid by MCOs, should be set to attract and retain direct service workers. Rates for direct service workers who support persons with IDD must take into account the lifelong needs of persons with IDD and the distinct skills and abilities required to teach persons to perform tasks independently.
4. HHSC needs to develop a strong reporting mechanism from the date of request or determination for the need of assessment for CFC services until the date the services are rendered or denied. HHSC needs to include in the reporting reasons why members may decide to decline the benefit.
5. HHSC with support of the legislature should establish a clear and streamlined funding mechanism and payment rate for the LIDDAs to perform eligibility determinations and CFC functional assessments for persons with IDD. This includes funding mechanisms and rates for CFC eligibility and/or assessments for persons with IDD who receive CFC in non-waiver programs such as STAR Plus, STAR Kids and STAR Health.
6. HHSC needs strong oversight and training for MCOs, LIDDAs, providers and CDS employers on the CFC benefit. This includes when to provide, how to report and how to bill for services. Training should also include information on how to provide habilitation for persons with IDD, as well as additional resources. Habilitation providers, as members of the Service Planning Team, should contribute to the development of outcomes, implement strategies to achieve habilitation goals, and report progress on a regular basis.
7. Allow flexibility within the CFC benefit, utilization policies, and person-centered planning such as:
    a. The ability to access CFC habilitation services from one provider to more than one person at the same time taking into account appropriate rates.
    b. Allowing through the amendment to the HCS and TxHmL waiver individuals living in the household of the waiver recipient to provide CFC if they meet the qualifications and want to be the provider.
    c. For all flexible changes, the system should not pressure families to use natural supports further overburdening family members caring for their family member. This includes any tools requiring use of natural supports.
8. Use data-driven decision-making to commit to ongoing evaluation and improvement in CFC. HHSC should work in concert with the MCOs and LIDDAs to allow for identification and tracking of CFC utilization data for specific

populations (i.e. persons with IDD). Once gathered and reviewed, utilization data should be used to address network adequacy. Data should be analyzed to determine additional training needs and process improvement.

9. HHSC should work with MCOs and LIDDAs to identify and address issues related to the sharing of information such as referrals, eligibility determinations and the authorization processes that slow down or impede enrollment. The current process does not work well, is prone to errors and inconsistency. The process should be streamlined and should not be administratively burdensome.
10. HHSC should recognize that a person remains eligible when eligibility was determined by a Determination of Intellectual Disability (DID) assessment completed after age 18. The requirement for a DID update every 5 years should only apply to a person whose eligibility was determined by a DID completed prior to the 18th birthday.

Recommendations for the IDD Redesign Advisory Committee COVID Changes

Background

The HHSC has made many changes to the Medicaid and CHIP program as a result of the COVID-19 pandemic. Some of the changes should be considered on a long-term basis to address needs of Medicaid recipients and to prepare for future disasters. Changes made now will simplify future needs and will serve Medicaid recipients more efficiently.

Recommendations

1. Allow qualified individuals living in the same household as a person receiving waiver services to be providers of Community First Choice services. Currently, this is not allowed in TxHmL and HCS programs. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. Parents of minor children and spouses are not qualified providers.
2. During an emergency or disaster allow Consumer Directed Services (CDS) employers of record to be the providers of CFC services, unless the individual is their own CDS employer of record. Currently this is not allowed in the CDS option. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. Parents of minor children and spouses are not qualified providers.
3. To hasten the employment process in both the instances addressed above, recommendations 1 and 2, defer the new employee requirements for family members of the individuals receiving services during an emergency or disaster. These would be the same deferments in place for all programs in regard to the crisis.
4. Allow for individuals in different waivers to share attendants when deemed appropriate in accordance with the individuals person-centered plan and ensure flexibility in rates when an attendant is supporting more than one person.
5. Expand the use of telehealth beyond the COVID-19 public health emergency and allow services to be provided and allow services to be provided via telehealth including therapy, targeted case management and service coordination when appropriate.

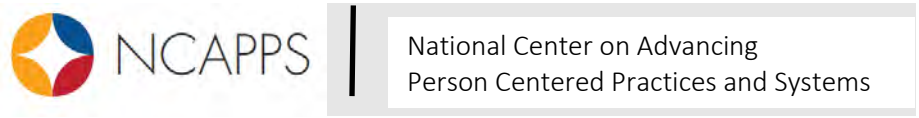
6. HHSC should include telemedicine and telehealth in each MCOs network adequacy plan.
7. Allow for and expand the use of remote telemonitoring with an individual's permission. During this crisis, use of remote telemonitoring has been helpful in monitoring the health of vulnerable populations. Telemonitoring devices can include those used to monitor diabetes, heart conditions, falls, and many other monitoring devices that can be helpful to ensure the individuals well-being.
8. Allow the continued use of televisit and telephonic assessments in all Medicaid home and community-based services waivers beyond the conclusion of the public health emergency and allow for verbal approval of mandated forms with written documentation of the verbal approval. In-person visits will still be done for those deemed at risk of abuse or neglect or upon request. During the pandemic, HHSC has allowed certain assessments and face-to-face contact with the Medicaid recipient to be done virtually. These changes have been welcomed by both the Medicaid recipients and assessors, and have increased efficiencies.
9. HHSC should add Personal Protective Equipment (PPE) as a reimbursable Medicaid benefit for all recipients including those using Consumer Directed Services.
10. HHSC should include IDD providers and CDS employers to the list of essential providers who need PPE and ensure they get the PPE needed during COVID-19 and any other public health emergency.
11. All Person-Centered Plans for persons with IDD should include a communication plan that can be used to communicate the person's needs in the event the individual is separated from their primary care provider due to hospitalization or other circumstance.
12. HHSC should extend all Medicaid waiver plans of care, level of care assessments, and CFC assessments expiring during the pandemic by one year as allowed by the state's CMS approved Appendix K submissions. This will allow Medicaid recipients in wavier programs to continue to receive services while protecting them from additional exposure.
13. HHSC should require Medicaid managed care health plans to expand their emergency disaster plans to include situations such as a pandemic rather than only natural disasters such as hurricanes.
14. HHSC should include screening for early detection and identification of abuse and neglect during times of crisis.
15. HHSC should streamline the Medicaid provider enrollment by combining and using one vendor for Medicaid managed care credentialing verification and HHSC Medicaid provider enrollment. HHSC relaxed some of the requirements for becoming a Medicaid provider during this COVID-19. This was crucial in allowing providers to become enrolled to provide telehealth services. However, prior to the crisis, becoming a Medicaid provider had become a long complex process often taking many months to complete. Once completed then the provider must become credentialed by Medicaid managed care health plans. The health plans simplified the process by use of one entity to assist providers for all the Medicaid managed care plans. The same changes are needed to the burdensome Medicaid enrollment process.
16. Allow the use of on-line CPR training and certification such as the training offered by the American Heart Association during and beyond the COVID-19 public health emergency. HHSC should allow for modifications to CPR training and certification requirements in all Medicaid waivers to allow for onboarding of

new employees and recertification of existing employees during a public health emergency.

17. Permanently remove the 30-day spell of illness limitation for hospitalizations for adults in the STAR+PLUS and fee-for-service programs. This has been a concern during this COVID crisis for Medicaid recipients who have exceeded the 30-day length of stay for COVID 19.
18. HHSC should seek approval from CMS to delay the implementation of EVV until the current public health emergency has ended or until an effectively working vaccination is in place. EVV implementation is set to begin on July 2020 for IDD providers and for Medicaid recipients utilizing CDS and acting as an employer. We know this is a time when many families are taking care of their loved ones, working if possible and coordinating care for their Medicaid recipient. It will be difficult for an additional task to be added while trying to keep their families safe at home.
19. HHSC should allow the use of social determinants of health to develop value-added services. During this crisis health plans have been asked to support food, housing, PPEs and other social determinants of health services. Additionally, HHSC should issue a list of Social Determinants of Health supports that health plans can provide in lieu of services.
20. Amend the Medically Dependent Children Program (MDCP) to create a nursing facility diversion target group for children with medical fragility who are at imminent risk of nursing facility admission. Currently it is the only program that requires institutionalization through a nursing facility to access crisis diversion slots through Medicaid. Requiring that this population be exposed to additional risks by staying in a nursing facility for up to 30 days puts the medically fragile person at risk.
21. HHSC should develop televisit options for the provision of some attendant and habilitation services for persons with IDD. There are some services that attendants can provide during a crisis such as teaching and verbally prompting a person through the completion of a task such as doing the laundry and making a meal.
22. HHSC should not reduce waiver eligibilities, services or budgets if persons are temporarily under-utilizing the services in their budget due to emergencies or pandemics like COVID-19.

Appendix D. National Center on Advancing Person-Centered Practices and Systems

Texas Technical Assistance Plan[51]



Technical Assistance Plan: Texas

Primary Contacts and Lead Agencies

Primary contact: Mary Bishop, Person-Centered Practices Team Lead, HHSC, Medicaid/CHIP Policy and Program (secondary contacts Jennie Costilow and Terry Wendling)

Texas NCAPPS Team:

- Jennie Costilow, HHSC, Manager/Director II (as of 7/1/20), Medicaid/CHIP Policy and Program Development
- Terry Wendling, HHSC, Person-Centered Practices Specialist
- Kirsten Coleman, HHSC, Policy and Program Development Program Specialist
- Jay Smith, Project Manager, HHSC Office of Disability Prevention for Children
- Mike Downey, Vice President of Mental Health Services, and Keena Pace, The Harris Center
- Jamie White, Director of IDD Services, Gulf Coast Center, Gulf Coast Center
- Dr. George Bithos, The Office of Independent Ombudsman for State Supported Living Centers
- Jonas Schwartz, Texas Workforce Commission - Vocational Rehabilitation Division
- Noah Abdenour, Director of Peer Services and Wendy Latham, Training Specialist, HHSC, Peer Services Unit
- Carrie Bradford and Mary Cloud, HHSC, Office of Acquired Brain Injury
- Jennifer Chancellor-Hurd, HHSC, Manager, Long Term Services and Supports (LTSS) Policy Unit, Medicaid and CHIP Services
- Lauren Bledsoe, HHSC, Senior Policy Analyst, Office of Mental Health Coordination

[51] The NCAPPS Texas Technical Assistance Plan is under development and adjusted ongoing as the plan develops. Texas NCAPPS Technical Assistance Plan included in this report includes revisions from July 7, 2020.

- Wes Yeager, HHSC, Director, Office of Aging and Disability Resource Centers, Access and Eligibility Services/Community Access
- Holly Riley, HHSC, Manager, Aging Services Coordination
- Lauren Cox, HHSC Blind Children's Program
- Michelle Dionne-Vahalik, HHSC, Director Regulatory Services Division
- Norine Gill, private provider and lived experience as a sibling and care giver
- Laurie Pryor, HHSC, Manager, and Karissa Sanchez, HHSC Policy Specialist, Office of Independent Living Services Program, Rehabilitative and Independence Services, Health, Developmental and Independence Services, Medical and Social Services
- Christine Medeiros, HHSC, Program Manager and Gabi Simpson, Program Supervisor, Comprehensive Rehabilitation Services,
- Rehabilitative & Independence Services, Health, Developmental & Independence Services
- Maria Alonso-Sanchez, Executive Director, Border Region Behavioral Health
- Stanley Williams, Director of Strategic Initiatives, Community Healthcore
- Dena Stoner, HHSC, Director I, Medical and Behavioral Health Services

TA Staff

- HSRI Lead: Bevin Croft
- Subject Matter Experts: Stacey Manser, Michael Smull

Statement of Need, Expected Outcomes, and Progress to Date

Because Texas has a large and geographically dispersed population in urban and rural areas with diverse cultures and needs and a wide span of vocal stakeholder groups, HHSC has identified a need to align policy and practice across the state for all populations across the lifespan. To achieve this aim in the first year of NCAPPS technical assistance, HHSC formed and launched a Steering Committee, composed of agency leadership and key stakeholders including program participants and family members, to define and prioritize outcomes and action steps for achieving a person-centered and trauma-informed system. This entity supports HHSC's efforts to ensure a comprehensive continuum of care that reflects person-centered thinking, planning, and practice. The formation of this group was a primary focus of Year One of the technical assistance. The Promoting Independence Work Group (originally the Promoting Independence Advisory Council) served as a starting point for the Steering Committee. Originally formed in statute as an Olmstead-related Commission, the group's mission is to ensure there are services and supports for community living in Texas. In Year One, the Steering Committee met on two occasions, with additional meetings planned for Year Two. In addition, numerous

workgroups were formed, each with designated co-chairs. Those groups also began meeting with one another in Year One. The workgroups are:

1. Parallel Tracks: Trauma Informed Person-Centered Practices in the TX Support System Workgroup – AKA: Parallel Tracks Policy Workgroup
2. Policy
3. Outward Face of HHSC
4. Quality and Oversight
5. Employment and Meaningful Day Services
6. Framework for My Life Plan tool to identify applications and needed adaptations for all HHSC populations and services

The Steering Committee also formed a charter and a detailed plan for ensuring diverse representation regarding age, disability, race, ethnicity, culture, and other factors. In Year Two, the Steering Committee will continue to meet but will use primarily internal HHSC resources to sustain its efforts rather than NCAPPS TA. Goal 1 has been retained to keep these efforts on track, but very little targeted technical assistance will be allocated toward this goal.

A second technical assistance in Year Two will focus on developing and executing a strategy for ensuring HHSC leadership understanding, buy-in, and commitment to person-centered thinking, planning, and practice. The Steering Committee has determined that commitment from leadership is essential for continuing efforts to enhance person-centered practices in Texas.

HHSC has also begun to lay the groundwork for creating a person-centered and trauma-informed planning framework and accompanying tools, guidance, rules, policies, and procedures, including adaptations for use with all HHSC populations. One starting point is a planning tool, My Life Plan, designed to support person-centered planning and practice. The My Life Plan tool was developed through a process of stakeholder engagement and is based on principles of person-centered thinking. The tool has not yet been implemented in HHSC service settings and has been shared with the TA team. Additional work is needed to create a comprehensive person-centered planning framework. This may include vetting the My Life Plan tool with collaborators from other disciplines, and selecting additional tools as needed. Guidelines will need to be developed to adjust the framework for use in specific contexts of with specific populations. Successfully implementing the framework will also involve increasing staff competencies to use the tools in an appropriate manner in multiple contexts. HHSC hopes to further develop the framework and create a strategy for its implementation across programs and services. Successful implementation would involve creating instructions and guidance for administering tools as well as updating policies, rules, documents, forms, contracts, branding guides, and the HHSC website, among other

materials. HHSC would like to explore transitioning the framework into an electronic record that would link functional, behavioral, and other assessments and service planning documents electronically.

In addition to establishing a consistent person-centered and trauma-informed planning process, the Steering Committee (with support from NCAPPS TA if appropriate), will consider the following areas enhancing person-centered thinking, planning, and practice in Texas:

- Enhancing person-centered and trauma-informed competencies among each agency's advisory committees and community members who are not part of the health and human services system but who interact with HHSC service users, such as first responders: fire departments, sheriffs and police, and paramedics. This may include training and support to improve the quality of crisis response, promoting the use of psychiatric advance directives, and other activities.
- Providing assistance to incorporate person-centered and trauma-informed principles into work with Child Protective Services and Adult Protective Services through trainings and revisions of rules, policy, and procedure to support person-centered thinking, planning and practice (representatives from these groups will also be included on the Steering Committee).
- Promoting the growth of the peer support workforce in the state, including behavioral health peer support as well as other peer support models for persons with brain injury, intellectual and developmental disability, and others with long-term service and support needs.
- Ensuring initiatives related to person-centered thinking, planning, and practice are aligned with Employment First policies and initiatives.
- Partnering with the state's Employment First efforts to ensure person-centered and trauma-informed principles are incorporated into initiatives promoting employment for people with disabilities.
- Developing quality metrics, utilization review practices, and other alternative payment models using a person-centered perspective.

Period of Performance

Year two: October 1, 2019 to September 30, 2020 (completed objectives are retained in gray, and draft objectives for future years are included in gray)

Outcomes and Objectives

Outcome 1: By September 30, 2020, HHSC will establish a person-centered Steering Committee and strategic plan for ensuring person-centered thinking, planning, and practice throughout the HHSC system.

Domain (*indicate all that apply: Practice, Payment, Policy*): Policy, Participant Engagement

Participant Engagement Strategies: People with lived experience (service users, families, and advocates) will be key members of the Steering Committee, and their engagement and representation will be enhanced through continuous implementation of the participant engagement strategy that was established in Year One of NCAPPS TA.

Note: The Texas team has identified internal resources to support Outcome 1 in Year Two. The NCAPPS TA Lead (Bevin Croft) will provide support for objectives in this outcome during monthly TA videoconferences as needed.

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.1 The Texas Team will create a participant engagement plan, with particular consideration given to ensuring meaningful representation of people with lived experience who represent HHSC service user populations on the Steering Committee, and mechanisms for gathering feedback from the community on the strategic plan	Participant Engagement Plan	Suggestion of strategies and supplying resources for ensuring participant engagement on the steering committee and engaging with the community Review of draft plan to ensure broadest possible representation TA Hours: 10	Robust stakeholder engagement networks within Texas	Mary Bishop & Jennie Costilow	**8/31/19** **COMPLETE** – although the participant engagement plan is a living document, and strategies are ongoing
1.2 Identify and secure engagement with all relevant stakeholders, including service users and families	Informational materials introducing the initiative Committee Roster	Assist with development of informational materials for recruitment TA Hours: 2	The Promoting Independence Work Group will serve as the core/starting point for this group.	Mary Bishop & Beren Dutra	**9/30/19** **COMPLETE** – although identification and engagement are ongoing process

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.3 Create a draft steering committee charter that includes group aims, roles and expectations of members, and definitions of key terms	Draft Committee Charter	Provide example charters Review draft charter before it is shared with the steering committee TA Hours: 5		Mary Bishop, Jennie Costilow, & Phyllis Matthews	6/30/19 **COMPLETE**
1.4 Hold a kickoff meeting of the person-centered steering committee to finalize the charter and NCAPPS TA	Kickoff meeting completed Finalized Committee Charter	Support agenda development Attend meeting to introduce the project and answer questions Attend and co-facilitate meeting TA Hours: 26	Meeting is scheduled for 6/28/19	Mary Bishop, Beren Dutra, and Jennie Costilow	6/30/19 **COMPLETE**
1.5 Hold a second meeting of the person-centered steering committee focused on developing parameters, outcomes, and objectives for the strategic plan	Second meeting Draft strategic plan outcomes and objectives	Attend meeting (via videoconference) TA Hours: 3		Mary Bishop, Beren Dutra, and Jennie Costilow	9/30/19 **COMPLETE** Meeting was held 8/23/19

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.6 Share an overview of the initiative and its outcomes at the Texas and Southwest Friends Gathering	Materials shared with Gathering attendees	TA Hours: 0	Meeting is November 6-8, 2019, and the presentation is on the agenda	Mary Bishop & Jennie Costilow	11/8/19 **COMPLETE** Jennie did an overview of the history of the initiative, and Mary delivered a presentation about where things are going
1.7 Develop a template for the strategic plan and a consistent structure and guidance for Steering Committee and workgroup activities.	Strategic plan template; Written structure and guidance for Steering Committee and workgroups	TA Hours: 0	The Steering Committee charter will serve as the starting point for this work along with materials on strategic planning best practice	Mary Bishop, Jennie Costilow, & Phyllis Matthews	11/30/19 Update: 1/17 the draft plan was sent to Steering Committee & Workgroups were asked to review & make recommended changes for next meeting on 2/28/20 **Completed** as of 2/28/20

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.8 Establish a SharePoint site accessible by all Steering Committee members and post all relevant documents on the site	SharePoint site established and shared with all Steering Committee members; All relevant documents posted on SharePoint	TA Hours: 0	HHSC has a SharePoint license and capability to set up a site. All Steering Committee members should have access	Phyllis Matthews & Christine Medeiros' team	**Site Development.** 11/30/20 – Began. 2/19/20 – Initial site development completed. **Site permissions (SP).** 1/28 & 31/20 Email notifications & SP invitations sent. 2/18/20 Testing of SP functionality & site permissions continue. 3/16/20 – Routine changes on-going and review/troubleshooting continues. **Upload of documents** - 2/26/20 emailed co-chairs with information re: adding calendar events & requested they upload workgroup documents. **Completed** as of 2/26/20

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.9 Continue to hold Steering Committee meetings to share information and develop the Strategic Plan.	Steering Committee Meetings are held monthly	Attend meeting (via telephone or in person) Review materials Support team to provide clarity to the workgroups regarding their charge and scope TA Hours: 4 HSRI	Monthly meetings have been scheduled	Mary Bishop, Jennie Costilow, Phyllis Matthews & Beren Dutra As of 7/1/20 Terry Wendling will be replacing Phyllis Matthews and Kirsten Coleman will replace Beren Dutra	**By/ 9/30/20** Meetings held: 10/18/19 11/15/19 12/13/19 1/17/20 2/28/20 The following were canceled because of COVID-19: 3/27/20 5/15/20 6/26/20 Meetings are scheduled for: 7/17/20 9/18/20 11/6/20 Starting 7/17/20 meetings will be held about every 8 weeks

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.10 Continue to implement the participant engagement strategy to increase representation of people with lived experience on the Steering Committee	-Members include at least two people with lived experience of receiving HHSC services and people who reflect the demographics of Texas on each Steering Committee Work Group	TA Hours: 0	Participant engagement knowledge and skills among existing members	Mary Bishop and Workgroup Co-Chairs	**By 9/30/20** As of 1/17/20, 3 additional people with lived experiences joined As of 6/25/20 this effort continues
1.11 With guidance and oversight from the person-centered Steering Committee, develop the two-year strategic plan for ensuring person-centered thinking, planning, and practice occurs throughout the HHSC system	Strategic Plan is developed and presented to HHSC Leadership	TA Hours: 0	Knowledge and resources from Steering Committee	Mary Bishop, Jennie Costilow, Phyllis Matthews and Dena Stoner As of 7/1/20 Terry Wendling will be replacing Phyllis Matthews	**By 4/30/20** **COMPLETE** On 1/30/20 Stephanie Muth, Medicaid Director (MD) received a copy of the draft strategic plan and notebook of PCP efforts On 5/1/20 Stephanie Muth retired and on 5/1/20 Stephanie Stephens, former Deputy Medicaid Director was promoted to SMD

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.12 Create a crosswalk of the draft strategic plan with the Employment First Policy to ensure alignment, and revise the strategic plan if needed.	Crosswalk of strategic plan and Employment First policy; Revised strategic plan to align with Employment First policy	During monthly videoconferences, facilitate/review crosswalk and revisions TA Hours: 0	SRAC Day Habilitation and Employment sub-committee, Employment and Meaningful Day Workgroup	Texas Workforce Commission, Texas Education Agency (contact TBD) Jonas Schwartz, Nehtra Davis, & Terry Wendling will co-chair the workgroup	By **9/30/20** As of 2/3/20 the HHSC co-chair stepped down to simply be a member. Efforts to find a new co-chair who is a HHSC Employee are underway As of 6/15/20 Terry Wendling will be co-chair of this committee
1.13 Work with leaders of other trauma-informed initiatives in the state to ensure alignment across initiatives and include trauma-informed considerations in the strategic plan.	Strategic plan to reflect current trauma-informed initiatives	During monthly videoconferences, facilitate/review crosswalk and revisions TA Hours: 0	Road To Recovery, funded by the Hogg Foundation is supporting the train-the-trainer initiative for trauma-informed care in TX	Mary Bishop, Dr. Scott LePor, Dr. Ryan Van Ramshorst and Parallel Tracks Workgroup	By **9/30/20** Parallel Tracks Workgroup continues to meet.

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.14 Hold a public webinar to share the strategic plan with stakeholders (service users and families, HHSC Support Services, advocates, and other interested stakeholders)	Public webinar, posted online with solicitation of public comments through Govdelivery, Texas Register, and other communication mechanisms	During monthly videoconferences, support developing and/or reviewing webinar materials TA Hours: 0	Presentations at the following meetings: COP April 2020, IDD SRAC, TX Council on Consumer Direction, Conferences: HHSC will use GovDelivery to share plan with stakeholders and announce the upcoming webinar.	Mary Bishop, Beren Dutra, Phyllis Matthews, Jennie Costilow, Legal, Workgroup Co-Chairs, and John Seagraves As of 6/15/20 Terry Wendling will be replacing Phyllis Matthews, and as of 7/1/20 Kirsten Coleman replacing Beren Dutra. As of 7/1/20 Jennie Costilow is now the Director II for Policy and Program Development.	Postponed to Year 3

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date and Status
1.16 Post the strategic plan for public comment with subsequent evaluation and revision to ensure it crosses the trajectory of life and all HHSC programs	Finalized Strategic Plan posted online with solicitation of public comments through Govdelivery, Texas Register, and other communication mechanisms	Review public feedback Review final strategic plan TA Hours: 0	Stakeholders will be able to provide formal comments through publication in the Texas Register as required for rule changes and public meetings. HHSC will also work to identify other methods to collect stakeholder feedback such as Gov Delivery and Tribal contacts	Mary Bishop, Beren Dutra, Phyllis Matthews, Jennie Costilow, Legal, Workgroup Co-Chairs, and John Seagraves As of 6/15/20 Terry Wendling will be replacing Phyllis Matthews, and as of 7/1/20 Kirsten Coleman replacing Beren Dutra.	Postponed for Year 3

Outcome 2: By September 30, 2020, the Steering Committee will develop and execute a strategy for ensuring HHSC leadership understanding, buy-in, and commitment to person-centered thinking, planning, and practice.

Domain (*indicate all that apply: Practice, Payment, Policy*): Policy

Participant Engagement Strategies: Participants and families will be engaged to develop and review informational and training materials for HHSC leadership.

TA Description (*include TA activities and projected hours*)	**Milestone**	**TA Description (*include TA activities and projected hours*)**	**Additional Resources to be Leveraged**	**Responsible Entity**	**Completion Date**
2.1 Develop a strategy for ensuring HHSC leadership buy-in and commitment	Leadership commitment strategy that includes account of current assets and areas for improvement	Review current leadership structures and roles within HHSC; Identify assets and gaps in leadership understanding, buy-in and commitment TA Hours: 30 Stacey Manser	Steering Committee members have deep understanding of system dynamics and roles	Mary Bishop and Jennie Costilow	7/31/20 Organizational Charts being provided to Stacey began 1/31/20 more were delivered on 2/27, with more to come. Stacey met with JR Top re the Environmental Scan on 2/27/20 and with Mary Bishop is scheduled for 2/28/20 Due to COVID-19 this date will need to be extended. On 6/10/20 a meet was held with Stacey to assist in development of a schedule of virtual training for leadership, after the direction by Emily Zalkovsky, Deputy Associate Commissioner for Policy and Program Medicaid/CHIP Services to establish the time frames on 6/2/20.

TA Description (*include TA activities and projected hours*)	Milestone	TA Description (*include TA activities and projected hours*)	Additional Resources to be Leveraged	Responsible Entity	Completion Date
2.2 Conduct a one-day workshop with key leadership to enhance understanding, buy-in, and commitment to person-centered thinking, planning, and practice	Workshop conducted; Attendance by leaders identified through activities in Objective 2.1	Conduct workshop TA Hours: 25 Michael Smull	Steering Committee members have existing relationships with key leaders; Steering Committee structure and work to date will provide a firm basis for leadership to put their learnings into action	Mary Bishop and Jennie Costilow	By 9/30/20 Due to COVID-19 all trainings are virtual. Stacey is in the process of setting up a schedule with Michael Smull for the training to occur. This date will need to be extended.
2.3 Revise leadership strategy based on information and impressions from the workshop with leadership.	Revised leadership strategy	Revise strategy based on information gathered during the leadership workshop TA Hours: 5 Michael Smull, 5 Stacey Manser		Mary Bishop and Jennie Costilow	By 9/30/20 Due to COVID-19 this date will need to be extended.

Outcome 3: By December 31, 2021, HHSC will create a person-centered planning framework and accompanying tools, guidance, rules, policies, and procedure, including adaptations to allow for use with all HHSC populations.

Domain *(indicate all that apply: Practice, Payment, Policy)*: Practice, Policy

Participant Engagement Strategies: The person-centered steering committee, which will include representation of people with lived experience, will be instrumental in this work. In addition, specific objectives are focused on ensuring relevance to diverse service user and family populations throughout the state.

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date
3.1 Conduct an environmental scan of current person-centered planning tools, guidance, rules, policies, and procedures within the HHSC system	Texas environmental scan	Support HHSC staff completing the scan TA Hours: 10	Some members of the Team completed a similar scan in the past (pre-HHSC) and as part of compliance activities for the settings rule	Mary Bishop & Policy Workgroup	9/30/19 **COMPLETE** with on-going process of identification and engagement
3.2 Working with an environmental scan of cross-agency/ cross-population person-centered planning tools, policies, and procedures used nationally, identify those most relevant for Texas	National environmental scan	Complete scan TA Hours: 24		Suzanne Crisp, Subject Matter Expert	9/30/19 **COMPLETE**

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date
3.3 Engage with Intellectual and Developmental Disability System Redesign Advisory Committee (Stakeholders) to gather feedback on the My Life Plan as it stands prior to changes being made by the Strategic Planning Workgroup	Stakeholders review and make comments in the format provided in the word document by COB September 6, 2019 Information to be shared with Workgroup	None	Began 8/19/19	Béren Dutra & Mary Bishop	9/30/19 **COMPLETE** Combined feedback received on 9/16/19. My Life Plan Workgroup now reviewing the feedback
3.4 Engage with the Texas Council on Consumer Direction, SRAC and other interested stakeholders on progress of developing the framework and other NCAPPS TA Activities	Provision of update on framework, including My Life Plan, and NCAPPS TA activities	TA Hours: 0	Committee liaisons and SMEs	Béren Dutra, Mary Bishop, and Phyllis Matthews	10/24/19 **COMPLETE**

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date
3.5 Create a draft framework to accompany the My Life Plan tool that will form the basis of reviews to occur in Year Two	Draft planning framework that includes tools (including the My Life Plan), guidance, rules, policies, and procedure	Support development of the framework Review preliminary drafts TA Hours: 5 HSRI	Local and national environmental scans completed in Year One	Mary Bishop, Framework for "My Life Plan", Co-Chairs Norine Gill, Noemi Smithroat, & Jennifer Caruso	**9/30/20** This work continues and as of 6/17/20 the plan will focus on Medicaid LTSS. This includes STAR+PLUS, STAR Health, STAR Kids (including MDCP), the 4 IDD waivers (HCS, TxHmL, CLASS, DBMD) and SP3 (the STAR+PLUS Pilot). The ultimate goal is to expand this tool to all programs.
3.6 Engage with Steering Committee to review the framework and My Life Plan tool and provide recommendations to update frameworks based on the review	Completed review; Recommendations for revision	Support facilitating reviews TA Hours: 6 Michael Smull (may also engage Cameron Camp in review)	Internal and external subject matter experts (SMEs) to include Michael Smull and Cameron Camp	Mary Bishop and My Life Plan Workgroup	**9/30/20** Due to COVID-19, this date will need to be extended. As of 6/17/20 it was suggested SMEs at HHSC review the entire document at some point to ensure there are not programmatic concerns and of course the SMEs will be happy to assist with completion of section IV for each program if needed

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date
3.7 Revise the person-centered planning framework and accompanying policy and procedure based on the environmental scans and reviews	Revised framework	Support interpreting feedback and creating revision TA Hours: 0	Internal and external subject matter experts (SMEs)	Mary Bishop, My Life Plan & Policy Workgroups	TBD
3.8 Identify and develop training for implementation of the framework	Development of training and implantation of Person-Centered Framework	Support training identification and development	TBD	Mary Bishop, My Life Plan Workgroup & HHSC Curriculum Developers	TBD
3.9 Create a strategy for implementing, create instructions / guidelines for implementation of the framework	Development and implementation of instructions/guidelines for Person-Centered Framework	TBD	TBD	Mary Bishop, My Life Plan Workgroup and Steering Committee	TBD

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date
3.10 Field test the person-centered planning framework in a range of settings and with a range of populations reflective of the HHSC system. Field testing will be conducted with a range of populations and will include IT considerations.	Results of field testing	TBD	TBD	Mary Bishop, My Life Plan Workgroup	TBD
3.11 Revise the person-centered planning framework based on the results of the field testing	Revised framework	TBD	TBD	Mary Bishop & My Life Plan Workgroup, IT	TBD
3.12 Post the person-centered planning framework for public comment	Public posting	TBD	TBD	Mary Bishop, Web-Services, Gov-Delivery	TBD

Objective	Milestone	TA Description *(include TA activities and projected hours)*	Additional Resources to be Leveraged	Responsible Entity	Completion Date
3.13 Hold at least three informational webinars to introduce the person-centered planning framework and invite public feedback	Informational webinars; Public feedback	TBD	TBD	Mary Bishop, & Jennie Costilow	TBD
3.14 Revise the person-centered planning framework based on the public comment	Finalized framework	TBD	TBD	Mary Bishop, My Life Plan Workgroup	TBD

Additional Details and Background Information

Detail about Technical Assistance Approach

Describe any relevant detail about the planned TA approach. For example, note plans/rationale for site visit, partnerships to explore, and role of other stakeholders.

The NCAPPS TA Lead and Subject Matter Experts (as needed) will meet with the Texas Team on a monthly basis. Currently, monthly videoconferences are held the first Tuesday of every month at 10am Central Time. Texas chose to pause the TA project in March through June, 2020, due to COVID 19.

Anticipated Resources for Public Sharing

Indicate products (including technical resources, presentations, policies and protocols, or programmatic tools) that might be shared or posted as resources on the NCAPPS website.

- Person-centered Steering Committee charter
- Person-centered Strategic Plan

- National scan of person-centered planning tools, policies, and procedures (completed in Year 1)
- Materials from leadership training
- My Life Plan tool

Specific Plans for Stakeholder Engagement

Detail specific plans for stakeholder engagement in the technical assistance process itself.

Texas HHSC relies heavily on stakeholder involvement for all policy and program development, as evidenced by its robust network of stakeholders who are active through formal advisory committees and councils, and less formal work groups and other venues. All these activities incorporate individuals who receive services, families, professional advocates, associations, providers, managed care organizations, and other important groups. Members of these groups will be engaged in the TA process. More detail about specific stakeholder engagement activities are described for each area of work. In Year One, the team developed a participant engagement plan that was shared with the full Steering Committee and all sub-committee Co-Chairs. This plan is a "living document" that will continue to be updated as the work continues.

Additional Texas Health and Human Services Confirmed Collaborative Entities Include:

State Agencies/Departments

- State Supported Living Centers - Clair Benitez
- Quality Assurance - Frank Genco
- Department of Family and Protective Services - Jillian Bonacquisti and Kristen Jones
- Texas Workforce Commission – Jonas Schwartz and Howard Joseph, Jr.

Advocacy Groups

- Texas Advocates - Annessa Lewis and Brooke Hohfeld
- The Time is Now - Shelley Dumas
- HHSC Promoting Independence Workgroup - Holly Freed
- ADAPT of Texas - Bob Kafka and Renee Lopez
- Texas Association of Home Care and Hospice – Sarah Mills and Rachel Hammon
- Texas Parent to Parent - Linda Litzinger and Amy Litzinger
- Coalition of Texans with Disabilities - Dennis Borel
- Disability Rights Texas - Jeff Miller
- Disability Awareness Program of Texas - Randell Resneder
- Texas Health Care Association - Dorothy Crawford and Kevin Warren
- Every Child - Elizabeth Tucker

- The Arc of Texas - Ginger Mayeaux and Debbie Wilkes
- RecoveryPeople - Carl F. Hunter II
- Intellectual and Developmental Disability System Redesign Advisory Committee (IDD SRAC) - Linda Levine
- Coastal Bend Center for Independent Living – Judy Telge

University Centers for Excellence in Developmental Disabilities

- Texas Center for Disability Studies, the University of Texas at Austin - Amy Sharp, PhD, Laura Buckner, Joe Tate, and Jeff Garrison-Tate
- Texas A&M University - Meagan Orsag, PhD and Aimee Day
- Hogg Foundation for Mental Health, the University of Texas at Austin - Colleen Horton
- Steve Hicks School of Social Work, the University of Texas at Austin - Stacey Stevens Manser, PhD
- The University of Texas at Austin - Mary Anne Hettenhaus

Texas Council for Developmental Disabilities - Scott Daigle

Texas Council of Community Centers - Isabel Casas and Danette Castle

North Central Texas Council of Governments - Doni Green

Assistive Technology Unlimited - Detra D. Stewart

Via Hope - Amanda Bowman, Betsy Bunt, and Amy Pierce

AGE of Central Texas - Annette Juba

Self Advocates

- Bryce Phillips, member of Texas Advocates
- Jan Brown

Texas Community Centers

- Hill Country MHDD Centers - Ross Robinson, Jennifer Caruso, and Randall Consford
- Metrocare Services - Carrie Parks
- MHMR Authority of Brazos County - Bill Kelley
- MHMR Services for Concho Valley - Greg Rowe
- MHMR Tarrant County - Molly Hurst and Susan C. Garnett
- Tri-County Behavioral Healthcare – Kelly Shropshire
- Integral Care - David Evans
- Betty Hardwick Center - Jenny Goode

- Center for Health Care Services - Selina Catalá
- The Harris Center - Kenna Pace
- Nueces Center for Mental Health and Intellectual Disabilities – Mike Davis

Community Healthcore Collaborators

- Gregg County Sheriff Department
- Longview Fire Department
- City of Longview
- Episcopal Health Foundation
- Highway 80 Mission
- United Healthcare
- Longview Regional Medical Center
- Christus Health
- Cornerstone Quarters
- Optum
- Hogg Foundation of Mental Health - Colleen Horton
- Special Health Resources

Providers within Texas

- Prism Health North Texas (formally known as AIDS Arms) - Anntionete Morgan
- Girling Community Care Texas, an affiliate of Kindred at Home - Rose Dunaway
- Private Providers Association of Texas - Carole Smith
- Providers Alliance for Community Services of Texas - Sandy Frizzell Batton
- D&S Community Services - Robert Ham
- WorkQuest - J. Kyle Radford

Medicaid Managed Care Organizations (MCOs)

- Amerigroup – Carmen Casares-Cernoch
- Cigna HealthSpring - Shelly Adkins
- Community First Health Plans - Michelle Ryerson
- Community Health Choice - Jonna Kiel-Mack
- Cook Children's Health Plan - Mandy Brantley
- Driscoll Health Plan - Keisia Sobers-Butler
- BlueCross BlueShield of Texas - Kevin Worwood
- Molina - Caren Zysk

- Superior – Noemi Smithroat
- Texas Children's Health Plan - Aracely Olmeda

National Collaborators

- National Council of Certified Dementia Practitioners - Sandra Stimson
- The Center for Applied Research in Dementia - Cameron Camp, PhD

Anticipated Collaborations and Additional, Ongoing Engagement

- Tribes: Continuing communication with Tribal Liaison and providing training opportunities for person-centered practices trainings offered throughout the State. The tribes will be asked to identify someone within their tribe that would be a well-suited as a person-centered coach. These people would then be invited to a Person-Centered Coaching training. The person(s) identified as the coach as well as other identified point of contact within the tribe would be invited to be active on technical assistance collaborative interactions.
- MCOs: Educating the point of contact for each MCO about person-centered coaching. Following the education about Person-centered coaching, the point of contact would be asked to identify employees that would be a well-suited as a person-centered coach. Those people would then be invited to a Person-Centered Coaching training. The person(s) identified as the coach as well as other identified point of contact within the MCO would be active on technical assistance collaborative interactions.
- Additional collaborative efforts will include Nursing Facilities, Private Providers, State Supported Living Centers, Community Centers, and State employees to include Department of Family and Protective Services. These efforts will include continuation of person-centered thinking training, and person-centered coaching. Person-Centered Plan Facilitation Training will be provided to Certified Person-Centered Thinking Trainers so they can become certified to train other state collaborators. There will also be a collaboration with the Texas Advocates to provide People Planning Together Training. The institute on Person-Centered Practices will be providing the training for self-advocates to become Certified People Planning Together trainers.

Relevant Background Information

Note background work that has already been accomplished, relevant policy or programmatic contexts, and previously provided technical assistance that this request builds on.

The aim for the technical assistance is to systematize the progress that is currently being realized through collaborative efforts to become a person-centered system. Texas has made great strides toward a person-centered system since 2014 by instituting person-centered thinking training requirements for all case managers

and service coordinators in home and community-based programs and managed care organizations; requiring person-centered planning through contracts and program requirements; creating an online introductory course for service providers, families, and others; training many agency, provider, and contractor staff in person-centered thinking; training all ombudsmen at state supported living centers; training staff at many nursing facilities across Texas; working to incorporate person-centered practices in the child protective services adoption staff; developing capacity by achieving 19 state employees as certified trainers, two coaching trainers and two with mentor trainer status; and developing a person-centered planning tool. Texas HHSC has collaborated over the years with its University Centers for Excellence in Developmental Disabilities, Texas A&M University and The University of Texas at Austin, collectively known as the Institute for Person-Centered Practices, on assessments for Community First Choice and STAR Kids Medicaid managed care program; the state plan amendment for Community First Choice; and person-centered trainings using standards based on The Learning Community for Person-Centered Practices (TLCPCP). Texas offers providers or contractors to submit their own person-centered trainings that must meet the minimum standards based on TLCPCP. Approved trainings can be found on HHSC's Person-Centered Planning Website: https://hhs.texas.gov/services/disability/person-centered-planning/waiver-program-providers/person-centered-planning-pcp-training-providers.

Community of Practice

The State of Texas has an established Community of Practice (COP) that focuses on enhancing person-centered thinking throughout the state. This group meets once per year and was started through the Institute for Person-Centered Practices. The COP is led by a planning committee that includes TLCPCP Certified Mentor Trainers from both University Centers for Excellence in Developmental Disabilities (UCEDD), all of whom are parents with lived life experience along with Mary Bishop representing Texas HHSC. The Texas COP and technical assistance co-applicants (members of the NCAPPS TA Team) met most recently in May 2019, with a focus on dynamics and support for change agents. This was the third annual Texas Community of Practice meeting. Group members identified action steps to advance this work. The group hopes to create connections and secure buy-in and collaboration across diverse groups and agencies. The COP supports the work described in this NCAPPS TA Plan.

Music and Memory

National Council of Certified Dementia Practitioners (NCCDP) and The Center for Applied Research in Dementia - Cameron Camp, Ph. D. Director of Research Development Cameron@cen4ard.com has been partnering with the HHSC Quality Monitoring Program (QMP) to bring Alzheimer's disease and dementia care training to staff in nursing homes and other settings with the aim to improve the quality of care of people receiving supports. The curriculum is maintained for all QMP staff trainers. Music & Memory (M&M) provides people a way to operationalize abstract concepts of PC thinking as the program is rooted in the discovery of individual musical preferences and ensuring those choices are honored. The therapeutic process of going beyond music genre or a

favorite artist to drill down to specific songs for one's playlists results in stimulated memory and engagement. QMP has seen success in both the NFs and SSLCs as the process of determining favorite songs causes staff to connect with people they support that results in trust and empathy. Management in both settings reports using the "Henry video" as part of new employee orientation as well as an interview tool to determine an interviewees level of empathy. The person-centered techniques of M&M are a great weapon against the inappropriate use of anti-psychotics (AP) because M&M builds deeper relationships between staff and people they support.

Trauma Informed Care

Over the past few years Texas has made significant investments in building awareness about trauma-informed care (TIC) and implementing TIC practices. HHSC has brought Karyn Harvey, Ph. D. down on multiple occasions to provide trainings across the state on TIC for individuals with IDD. Additionally, HHSC developed 2 different web-based training modules on TIC for individuals with IDD for direct services workers and physicians. In 2018 HHSC partnered with SAFE Alliance, a non-profit organization whose mission is to stop abuse for everyone by serving the survivors of child abuse, sexual assault, trafficking, and domestic violence, to provide Road to Recovery trainings around the State. Finally, Texas' 13 State Supported Living Centers have all adopted Ukeru, which is a trauma-informed restraint-free crisis management technique based in the concepts of comfort vs. control.

Through a Substance Abuse and Mental Health Services Administration grant, legacy Texas Department of State Health Services developed The Texas Children Recovering From Trauma (TCRFT) initiative, which aimed to transform children mental health services in Texas into TIC services and foster resilience and recovery. The TCRFT initiative implemented trauma-informed best practices in the community mental health service delivery system for children and adolescents; including trauma screenings, assessments and trauma-focused evidence-based practices (EBPs). Texas wrapped up the four-year initiative with a four-day Trauma-Informed Care Summit in August 2016. The Summit consisted of two days of preconference workshops, including a training in TF-CBT and the Core Competencies for Childhood Trauma.

Most recently Texas has taken on a Trauma-informed Care transformation initiative, the mission of which is to develop a coordinated statewide approach for building a person-centered, trauma-informed behavioral health system and providing quality supports, services, and care to Texans. The trauma transformation initiative includes a cross-agency workgroup whose focus is on building and strengthening a coordinated trauma-informed behavioral health system across Texas. Parallel to the cross-systems effort, HHSC has established a Trauma Transformation Workgroup to focus on internal policies and organizational framework. The objective is to build trauma-informed culture through awareness of trauma and its impacts not only on clients and services, but on the broader organization, agency environments, and with a focus on staff wellness.

The Statewide Behavioral Health Coordinating Council (2016)

Required Council state agencies include: The Office of the Governor (OOG); Texas Veterans Commission (TVC); Health and Human Services Commission (HHSC); Department of Aging and Disability Services (DADS); Department of Family and Protective Services (DFPS); Department of State Health Services (DSHS); Texas Civil Commitment Office (TCCO); The University of Texas Health Science Center at Houston (UTHSC–Houston); The University of Texas Health Science Center at Tyler (UTHSC–Tyler); Department of Criminal Justice (TDCJ); Texas Juvenile Justice Department (TJJD); Texas Military Department (TMD); Health Professions Council has one seat representing the Texas Medical Board, Texas Board of Pharmacy, Texas Board of Dental Examiners, Texas Board of Nursing, Texas Optometry Board, and Texas Board of Veterinary Medical Examiners

Voluntary Council state agencies include: Texas Education Agency (TEA); Texas Commission on Jail Standards (TCJS); Texas Workforce Commission; Texas Department of Housing and Community Affairs (TDHCA). Texas is also a part of the Building Bridges and System of Care Initiatives.